



CHCS II Block 1 User's Manual Build 838

for the

Composite Health Care System II

Prepared for:

The CHCS II Program Office

and the

MHS Clinical Information Technology Program Office

27 July 2005

Prepared By:

Integic Corporation
Healthcare Practice Area
3675 Concorde Parkway, Suite 800B
Chantilly, Virginia 20151



Table 1: CHCS II Block 1 Changes

Functionality/ Change	Build	Module	Date
Replaced graphics in CHCS II Training System Module	838	CHCS II Training System	5/18/05
Added Failover Operations/Local Cache Module	838	Local Cache	5/18/05
Army Profiles	833.8 837	Army Profile	8/18/04
Training System Convergence	837	CHCS II Training System	8/18/04
Hear 3.0	833.8 837	PKC Couplers	8/18/04
Allergy/Appt Triggers	836	Appointments Allergies	7/16/04
APV Turn-off	833.8 836	Appointments (6.4) Disposition (13.2)	7/16/04
CAC	836	Getting Started (1.6)	7/16/04
HIPAA 837	836	Appointments (6.4) A/P (8.2) Disposition (13.2) Screening (36.3) Vitals (43.3) Navigation Patient Encounter	7/16/04
IBWA	836	Appointments (6.4) Patient Encounter Previous Encounters Medications (19.3)	7/16/04
Immunizations Ph 1	836	Immunizations	7/16/04
Snareworks 5.16	836	Getting Started (1.2)	7/16/04

Table 1: CHCS II Block 1 Changes

Functionality/ Change	Build	Module	Date
Wellness Enhancements	836	Wellness A/P (8.7) Reminder Mapping	7/16/04
Group A	835	Vitals (42.3)	4/29/04
Template Mgt Ph 1	835	Template Management	4/29/04
Medicomp Forms Tool	834	S/O (38.3)	3/9/04

Table 1: CHCS II Block 1 Changes

Functionality/ Change	Build	Module	Date

CHCS II User's Manual

Table of Contents

1.0 GETTING STARTED	1-1
1.1 CHCS II Overview	1-1
1.2 Security Overview	1-1
1.3 Account Creation Process.....	1-2
1.4 Transferring an Account from One MTF to Another MTF	1-3
1.5 Account Management	1-4
1.6 Logging Into CHCS II	1-4
1.7 Changing the CHCS II Password.....	1-7
1.8 Exiting CHCS II	1-9
1.9 Protecting Sensitive Material.....	1-9
1.10 Protecting Your Assigned Username and Password	1-9
1.11 Protecting Your Workstation	1-9
1.12 Break the Glass Privileges	1-10
2.0 CHCS II NAVIGATION	2-1
2.1 Navigation Basics.....	2-1
2.2 Customizing the CHCS II User Interface.....	2-2
2.3 Opening a Module.....	2-4
2.4 Closing a Module	2-4
2.5 Startup Options	2-4
2.6 Patient ID Bar.....	2-5
2.7 CHCS Access	2-6
3.0 FAILOVER OPERATIONS	3-1
3.1 Failover Operations Overview.....	3-1
3.2 Failover Mode	3-3
3.3 LCD Failure	3-5
3.4 CHCS Failure in Failover Mode	3-5
3.5 Failover Operations.....	3-6
3.6 Failover Mode Supported Modules	3-6

3.7 User Configuration Data.....	3-11
4.0 WORK FLOWS	4-1
4.1 Basic Front Desk Clerk Workflow.....	4-1
4.2 Basic Support Staff Workflow.....	4-1
4.3 Basic Provider Workflow	4-2
5.0 ALLERGY.....	5-1
5.1 Allergy Overview	5-1
5.2 Creating a Common List of Allergens	5-3
5.3 Adding an Allergy	5-4
5.4 Editing an Allergy	5-5
5.5 Deleting an Allergy	5-6
5.6 Verifying Allergies	5-6
6.0 ALERT REVIEW MODULE	6-1
6.1 Alert Review Overview.....	6-1
6.2 Addressing an Alert.....	6-2
6.3 Addressing New and Priority Result Alerts	6-2
6.4 Deleting an Alert.....	6-3
6.5 Viewing Details of an Alert	6-3
7.0 APPOINTMENTS	7-1
7.1 Appointments Overview	7-1
7.2 Setting the Properties of the Appointments Module.....	7-2
7.3 Filtering the List of Appointments.....	7-3
7.4 Creating a New Appointment	7-5
7.5 Checking In a Patient.....	7-9
7.6 Checking Out a Patient	7-10
7.7 Adding an Additional Provider.....	7-10
7.8 Transferring an Appointment.....	7-12
7.9 Canceling an Appointment.....	7-12
7.10 Printing the Insurance Form.....	7-13
7.11 Viewing a Comment Associated with an Appointment.....	7-13

8.0 ARMY PROFILE	8-1
8.1 Army Profile Overview.....	8-1
8.2 Creating a Profile Template	8-6
8.3 Using an Army Profile Template	8-7
8.4 Viewing and Printing the DA Form 3349.....	8-9
8.5 Deleting a Profile.....	8-9
8.6 Removing a User Profile Template	8-10
9.0 ASSESSMENT AND PLAN (A/P)	9-1
9.1 Assessment and Plan Overview	9-1
9.2 Associating Procedures, Orders, and Instructions.....	9-1
9.3 Documenting a Diagnosis	9-2
9.4 Creating an Order Set from A/P	9-5
9.5 Documenting a Procedure	9-7
9.6 Linking a Clinical Team Member to a Procedure	9-9
9.7 Addressing Reminders.....	9-11
9.8 Ordering a Consult.....	9-15
9.9 Ordering a Laboratory Test.....	9-18
9.10 Ordering a Radiology Procedure.....	9-28
9.11 Ordering a Medication.....	9-30
9.12 Requesting Location	9-33
9.13 Adding Patient Instructions	9-36
9.14 Discontinuing an Order	9-37
9.15 Placing an Order on Hold.....	9-37
9.16 Showing the Details of an Order	9-37
9.17 Renewing/Modifying an Order.....	9-38
10.0 CLINICAL NOTES.....	10-1
10.1 Clinical Notes Overview	10-1
10.2 Setting Time Preferences for the Clinical Notes Module.....	10-5
10.3 Creating a New Note.....	10-7
10.4 Editing a Note.....	10-8

11.0 CONSULT LOG.....	11-1
11.1 Consult Log Overview	11-1
11.2 Setting the Consult Log Filter.....	11-2
11.3 Setting the Consults Change Selection Criteria	11-2
11.4 Printing a Consult.....	11-3
11.5 Removing a Consult.....	11-4
11.6 Viewing the History of a Consult	11-4
12.0 Co-SIGNS	12-1
12.1 Co-signs Overview	12-1
12.2 Co-Signing an Encounter	12-1
12.3 Co-Signing an Encounter for Another Provider.....	12-2
12.4 Appending a Narrative	12-3
12.5 Amending an Encounter.....	12-5
13.0 DEMOGRAPHICS	13-1
13.1 Demographics Overview	13-1
13.2 Editing Demographic Information.....	13-2
13.3 Viewing Primary Care Provider Information	13-3
13.4 Modifying Special Work Status	13-3
13.5 Viewing DEERS Eligibility	13-4
13.6 Updating Required Fields.....	13-4
13.7 Printing the Insurance Form.....	13-5
13.8 Entering New Third-Party Insurance Information	13-5
14.0 DISPOSITION	14-1
14.1 Disposition Overview.....	14-1
14.2 Completing the Disposition	14-2
15.0 FLOWSHEETS	15-1
15.1 Flowsheets Overview	15-1
15.2 Viewing Flowsheets	15-1
15.3 Printing Flowsheets.....	15-2

16.0 HEALTH HISTORY	16-1
16.1 Health History Overview.....	16-1
16.2 Customizing the Health History Module	16-2
16.3 Viewing Historical Modules	16-2
17.0 IMMUNIZATION ADMIN	17-1
17.1 Immunizations Admin Overview.....	17-1
17.2 Adding User-Defined Groups	17-2
17.3 Adding a Refrigerator	17-3
17.4 Adding a Vaccine for Multiple Entry	17-5
17.5 Assigning Vaccines to User Defined Groups	17-6
17.6 Deleting Providers from Administering Immunizations.....	17-6
17.7 Entering Multiple Vaccines for a Patient	17-7
17.8 Logging Refrigerator Temperatures	17-8
17.9 Modifying Refrigerator Temperature Logs	17-9
17.10 Modifying a Refrigerator	17-10
17.11 Printing Immunization Reports	17-11
17.12 Selecting a Default Vaccination Clinic.....	17-12
17.13 Viewing the Vaccine Lot Number List	17-13
18.0 LABORATORY	18-1
18.1 Laboratory Overview	18-1
18.2 Creating a Search Filter in the Lab Module.....	18-1
18.3 Setting Laboratory Module Preferences.....	18-3
18.4 Viewing Lab Results.....	18-4
18.5 Viewing Sensitive Lab Results	18-5
18.6 Copying Lab Results to a Note	18-5
18.7 Printing Lab Results	18-6
19.0 LIST MANAGEMENT	19-1
19.1 List Management Overview.....	19-1
19.2 Adding an Item to a Favorites List.....	19-2
19.3 Deleting an Item From a Favorites List	19-3
19.4 Changing Location of Items on a List.....	19-3

20.0 MEDICATIONS	20-1
20.1 Medications Overview	20-1
20.2 Setting the Filter of the Medications Module	20-2
20.3 Documenting an OTC/Outside Medication.....	20-2
20.4 Ordering a New Medication.....	20-4
20.5 Reviewing a Medication	20-5
20.6 Discontinuing a Medication	20-6
20.7 Renewing a Medication.....	20-6
21.0 NEW RESULTS	21-1
21.1 New Results Overview	21-1
21.2 Viewing New Results	21-2
21.3 Discarding New Results	21-3
21.4 Saving New Results	21-3
21.5 Forwarding New Results	21-4
21.6 Tossing New Results	21-6
22.0 ORDER SETS.....	22-1
22.1 Order Sets Overview.....	22-1
22.2 Creating an Order Set from A/P	22-1
22.3 Using an Order Set in A/P	22-3
23.0 PATIENT ENCOUNTER	23-1
23.1 Patient Encounter Overview.....	23-1
23.2 Adding a Note	23-3
23.3 Deleting a Note	23-5
23.4 Editing a Note.....	23-5
23.5 Adding an Additional Provider	23-6
23.6 Loading an Encounter Template	23-8
23.7 Signing the Encounter Overview.....	23-9
23.8 Saving an Encounter as a Template	23-11
23.9 Unlocking an Encounter	23-12
24.0 PATIENT IMMUNIZATIONS.....	24-1
24.1 Patient Immunizations Overview.....	24-1

24.2 Adding a Vaccination	24-2
24.3 Deleting Immunization History	24-4
24.4 Editing Immunization History.....	24-5
24.5 Editing Vaccination Groups.....	24-6
24.6 Printing Immunization Records	24-7
24.7 Reviewing Immunization Records.....	24-7
24.8 Selecting an Immunization	24-7
24.9 Selecting the Immunization Exempt Type.....	24-8
25.0 PATIENT LIST	25-1
25.1 Patient List Overview	25-1
25.2 Adding a Patient Name	25-1
25.3 Deleting a Patient Name	25-2
25.4 Deleting the Entire List of Patients	25-2
26.0 PATIENT QUESTIONNAIRES.....	26-1
26.1 Patient Questionnaires Overview.....	26-1
26.2 Viewing Questionnaires in an Encounter Document.....	26-1
26.3 Assigning a Questionnaire to a Patient.....	26-1
26.4 Reviewing a Completed Questionnaire.....	26-4
27.0 PATIENT SEARCH	27-1
27.1 Patient Search Overview.....	27-1
27.2 Conducting a Search.....	27-1
27.3 Selecting a Patient Record Without a Search	27-3
28.0 PKC COUPLERS.....	28-1
28.1 PKC Couplers Overview	28-1
28.2 Running a New Coupler	28-1
28.3 Viewing a Completed Coupler.....	28-4
28.4 Updating a Completed Coupler.....	28-4
28.5 Using a Kiosk to Complete the HEAR Questionnaire	28-5
28.6 Finding Summary Report	28-6
28.7 Reviewing and Resolving the Finding Error Summary.....	28-7
28.8 Printing or Previewing a Report	28-8

29.0 PREVIOUS ENCOUNTERS.....	29-1
29.1 Previous Encounters Overview	29-1
29.2 Appending a Narrative	29-1
29.3 Amending a Previous Encounter.....	29-4
29.4 Creating a New Encounter Template	29-6
29.5 Copy Forward.....	29-8
29.6 Printing Previous Encounter Documents	29-10
30.0 PROBLEMS	30-1
30.1 Problems Overview	30-1
30.2 Viewing the Problem List.....	30-1
30.3 Adding a Problem.....	30-2
30.4 Adding an Historical Procedure.....	30-3
30.5 Adding Family History Problems	30-5
30.6 Updating a Problem or Procedure.....	30-6
30.7 Accessing Healthcare Maintenance	30-7
31.0 QUESTIONNAIRE SETUP	31-1
31.1 Questionnaire Setup Overview	31-1
31.2 Copying a Questionnaire.....	31-3
31.3 Deleting a Questionnaire.....	31-4
31.4 Importing a Questionnaire or Question into a Questionnaire	31-4
31.5 Maintaining Questionnaires.....	31-5
32.0 RADIOLOGY	32-1
32.1 Radiology Overview	32-1
32.2 Creating a Filter in the Radiology Module	32-1
32.3 Setting Time Preferences in the Radiology Module	32-3
32.4 Viewing Radiology Results.....	32-4
32.5 Printing Radiology Results	32-4
32.6 Copying Radiology Results to a Note	32-4
33.0 READINESS	33-1
33.1 Readiness Overview	33-1
33.2 Modifying Readiness Information.....	33-1

34.0 REMINDER MAPPING.....	34-1
34.1 Reminder Mapping Overview.....	34-1
34.2 Setting a Default Action.....	34-3
34.3 Mapping Encounter Terms.....	34-7
34.4 Managing Immunization Reminders.....	34-8
35.0 REPORTS	35-1
35.1 Reports Overview.....	35-1
35.2 Running Customized Reports	35-4
35.3 Running Preventive Reports	35-5
35.4 Running Standard Reports.....	35-7
35.5 Running Population Health Reports.....	35-8
35.6 Exporting a Report	35-9
36.0 RX ALTERNATIVES.....	36-1
36.1 Drug (RX) Alternatives Overview	36-1
36.2 Setting Drug Display Options	36-1
36.3 Adding a New Drug.....	36-2
36.4 Adding Therapeutic Alternatives	36-3
36.5 Deleting a Drug	36-4
37.0 SCREENING (REASON FOR VISIT)	37-1
37.1 Screening Overview	37-1
37.2 Adding an Additional Provider.....	37-1
37.3 Documenting the Reason for Visit.....	37-3
37.4 Adding Female Only Data	37-4
37.5 Verifying Allergies	37-5
37.6 Managing the Wellness Reminders	37-6
38.0 SCREENING NOTIFICATION	38-1
38.1 Screening Notification Overview	38-1
38.2 Selecting Screening Notification Reminder Search Options	38-2
38.3 Notifying Patients about Screening Services	38-4

39.0 SIGN ORDERS	39-1
39.1 Sign Orders Overview	39-1
39.2 Cancelling a Non-Provider Order	39-1
39.3 Signing Non-Provider Orders	39-1
40.0 SUBJECTIVE/OBJECTIVE (S/O)	40-1
40.1 Subjective/Objective Overview	40-1
40.2 S/O Templates Overview	40-3
40.3 S/O Template Personalization Overview	40-12
40.4 MEDCIN Forms Overview	40-27
41.0 TELEPHONE CONSULTS	41-1
41.1 Telephone Consults Overview	41-1
41.2 Setting the Properties of the Telephone Consults Module	41-2
41.3 Canceling a Telephone Consult	41-4
41.4 Editing the Callback Phone Number	41-4
41.5 Opening an Encounter	41-5
41.6 Creating a New Telephone Consult	41-5
41.7 Completing the Telcon Quick Entry Screen	41-6
41.8 Transferring a Telephone Consult	41-8
41.9 Viewing a Telcon Note	41-8
42.0 TEMPLATE MANAGEMENT	42-1
42.1 Template Management Overview	42-1
42.2 Organizing Templates	42-2
42.3 Moving Templates to Folders	42-4
42.4 Selecting an Encounter Template	42-5
42.5 Setting an Encounter Template as a Default	42-7
42.6 Creating a New Template	42-8
42.7 Searching for a Template	42-10
42.8 Editing a Template	42-12
42.9 Merging Templates	42-13
42.10 Copying a Template	42-15
42.11 Removing/Adding to Favorites	42-15

42.12 Importing/Exporting a Template	42-16
42.13 Deleting a Template	42-17
42.14 Saving an Encounter as a Template	42-18
43.0 CHCS II TRAINING SYSTEM	43-1
43.1 CHCS II Training System Overview	43-1
43.2 Logging into the Training System	43-2
43.3 Using the Training System	43-5
43.4 Patient Information	43-9
43.5 Removing the Training System	43-11
44.0 VITAL SIGNS	44-1
44.1 Vital Signs Overview	44-1
44.2 Setting the Properties of the Vital Signs Module	44-1
44.3 Entering New Vital Signs	44-2
44.4 Editing Vital Signs	44-5
44.5 Deleting Vital Signs	44-6
44.6 Graphing Vital Signs	44-6
44.7 Reviewing Vital Signs	44-7
44.8 Vital Sign Ranges	44-9
45.0 WEB BROWSER	45-1
45.1 Web Browser Overview	45-1
45.2 Changing the Internet Home Page	45-1
45.3 Accessing the Favorites List	45-3
45.4 Adding to the Favorites List	45-3
45.5 Organizing the Favorites List	45-3
45.6 Importing HTML Bookmarks	45-5
45.7 Exporting HTML Bookmarks	45-5
45.8 Printing Web Pages	45-6
46.0 WELLNESS	46-1
46.1 Wellness Overview	46-1
46.2 Setting the Filter for the Wellness Module	46-1
46.3 Setting Preferences for the Wellness Module	46-3

46.4 Due Reminders Tab	46–4
46.5 Documentation History Tab.....	46–8
46.6 Wellness Schedule Tab	46–13

1.0 GETTING STARTED

1.1 CHCS II Overview

As the target healthcare system of the Department of Defense (DoD), the Composite Health Care System (CHCS) II provides a structured framework for accessing and integrating medical information for patients. CHCS II is the Military Health System (MHS) Computer-based Patient Record (CPR). It provides the DoD with an enterprise-wide system, governed by universal standards integrating data from multiple sources and displaying the data at the point of care. Appropriate portions are easily accessible to authorized users when and where needed. The CPR facilitates the world-wide delivery of healthcare, assists clinicians in making healthcare decisions, and supports leaders in making operational and resource allocation decisions.

CHCS II provides the essential capabilities, as identified by the functional community, to support the creation of a CPR. CHCS II integrates the best of Government and commercial off-the shelf (COTS) products by interfacing the existing MHS Automated Information Systems with new functionality.

1.2 Security Overview

CHCS II is installed in Military Treatment Facilities (MTFs) and clinics throughout the world. As the security of patient data is of paramount importance in the military's healthcare community, an elaborate and effective security methodology has been built into CHCS II. The system administrator strictly controls access to all parts of CHCS II.

An integral part of CHCS II security is the assignment of roles. Each user is assigned a CHCS II role. This role is determined by the user's job skill set. These roles are cumulative, allowing greater access to patient information as roles are added. Similar in concept to the CHCS user level, an individual's role determines what information can be accessed or changed.

CHCS II is developed to provide an interface to data contained in the military health care systems. The CHCS II product provides the DoD clinical team members with a single-sign-on capability to retrieve patient data from multiple sources and locations without the need to manually access each information repository. With the single-sign-on feature, CHCS II account users are able to retrieve site information stored in the Clinical Data Repository (CDR) at Defense Information Systems Agency (DISA) and to access their local CHCS application. The CHCS II account resides on the Enterprise Master Security Server (EMSS) at DISA with local control at each Host MTF.

The local access to the Enterprise system is granted, managed and inactivated at the local sites using the local security object, similar to the CHCS account creation, granting access to the local CHCS. The management of the local access to CHCS II is designed to meet MHS and DoD account management guidelines, while the Enterprise account remains intact for successful transfer to other CHCS II MTFs and access to global user account information. Local sites do have the capability to delete the

Enterprise accounts in the event of a security violation. User accounts can and will be suspended after 45 days and disabled/inactivated after 120 days of non-activity, or when a user leaves the MTF.

The CHCS II Enterprise account enables users to transfer from one CHCS II MTF to another CHCS II MTF, for reassignment or Temporary Duty (TDY), and continue to access their CHCS II account settings, such as personal templates, and gain access to the new CHCS II MTF clinical information. This process is referred to as Transferring a CHCS II account.

1.3 Account Creation Process

CHCS II user account creation is an automated process. This process is initiated with the creation of the CHCS user account. Upon creating and flagging the CHCS user account with the settings “Active CHCS II user,” the user account information is sent to the CDR and to SnareWorks to create the user account on the EMSS. Once the EMSS receives the request for the account, the system sends an email to the Security Administrator(s) at the local site, notifying the site that the account is ready for activation. The site system administrator then assigns the appropriate roles and privileges and provides local access to the CDR and CHCS.

Upon CHCS II account accreditation, the Security Administrator, through a local process, notifies the user that his/her account has been accredited and he/she can proceed to log into CHCS II. The user logs in to CHCS II using the CHCS Access/Verify code and is prompted to change his/her password and enter a new User ID. This updates the CHCS Verify code (password) and provides the user with a username for entering CHCS II and CHCS (single sign-on), but does not change the CHCS Access code.

Note: According to the MHS Security Guidelines, the CHCS II password must meet the following criteria.

- Minimum of 8 and maximum of 20 characters
 - Minimum of 1 numeric character
 - Contain at least 1 of the following non-alphanumeric characters: !, @, #, \$, %, or &
 - Mixture of case
 - It should not be a previously used CHCS Verify code
 - @ sign cannot be used in the User ID or password
 - Passwords should not consist of words found in the dictionary
 - Should not be names, dates, etc., that are easy to guess
-

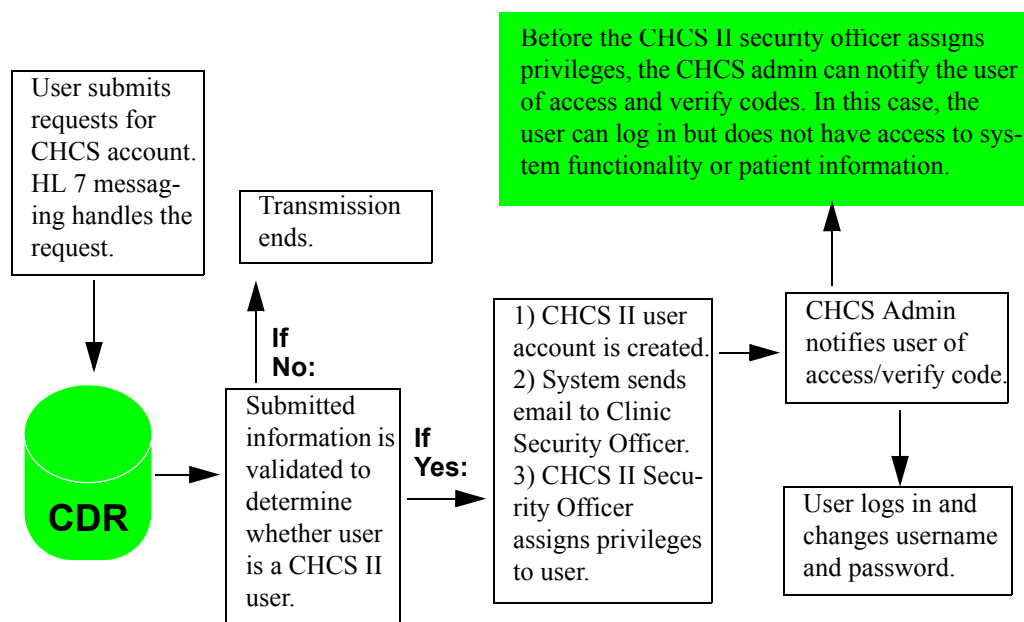


Figure 1-1: Account Creation Process

1.4 Transferring an Account from One MTF to Another MTF

Individuals who are on Permanent Change of Station (PCS) or are on Temporary Duty (TDY) to another CHCS II MTF can access their CHCS II account with the same user defaults and templates.

Follow the steps below to transfer an account to a new CHCS II MTF:

1. The user registers for a CHCS account at the new location to begin the account creation process. When account information is sent to the CDR, it is associated with the existing CHCS II information.
2. The system administrator at the new location must still credential the new account at the new MTF.
3. Once the Security Administrator accredits the local account with the CHCS II account information, the user is able to access the local CHCS and the site specific information on the CDR with his/her CHCS II User Name and Password. If the CHCS II account has not been accredited at the new MTF, the user can only access global information, such as Internet access.

Note: If a user prefers to have his/her new MTF Access and Verify code match his/her existing CHCS II User Name and Password, the user needs to contact the Security Administrator to have his/her account information updated.

1.5 Account Management

The ability to manage accounts is accessed through the local sites' Account Management web page. When users access the web page with their CHCS II logon information, they have the ability to reset passwords and change their personal contact information.

1.6 Logging Into CHCS II

There are two methods used to login to CHCS II:

- CHCS II icon on Windows desktop
- Common Access Card (CAC)

Follow the steps below to login to CHCS II from the Windows desktop:

1. Double-click the **CHCS II** icon located on the Windows Desktop. The Snare-Works security warning window opens.



Figure 1-2: CHCS II Icon

2. Review the information in the window and click **Acknowledge** to accept the security message. The Login window opens.



Figure 1-3: CHCS II Login Window

3. In the User ID field, enter the assigned User ID.
4. In the Password field, enter the assigned password.
5. Click **OK**. Upon successful login, the Military Clinical Desktop displays, configured as it was upon the last exit.

Note: This method of login is always available if you do not have a CAC or if login to CHCS II using your CAC fails.

Note: The CAC scanning option is currently only compatible with the 3-D Bar Code.

Follow the steps below to login to CHCS II using a CAC:

1. Double-click the **CHCS II** icon located on the Windows Desktop. The Snare-Works security warning window opens.



Figure 1-4: CHCS II Icon

2. Review the information in the window and click **Acknowledge** to accept the security message. The Login window opens.



Figure 1-5: Login Window

3. At the Login screen, insert your CAC and click **CAC Login**.
4. At the CAC Login screen, enter your PIN.

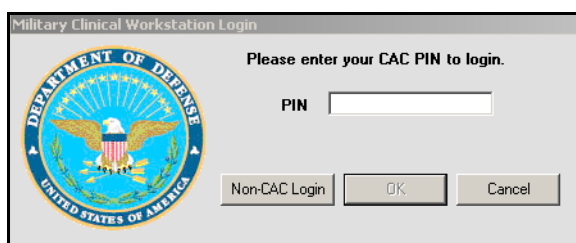


Figure 1-6: CAC Login

Note: The first time you use your CAC to login to CHCS II, after you enter your PIN, you are prompted to enter your normal User ID and password for validation purposes. Thereafter, you need only insert your CAC and PIN to login to CHCS II.

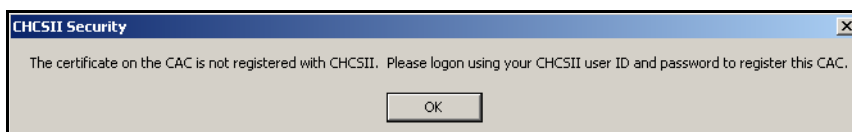


Figure 1-7: CHCS II Security Window

5. Click **OK**. The Login screen displays.



Figure 1-8: Login Window

6. Enter your CHCS II User ID and Password and click **OK**. You are logged into CHCS II. As stated in the Note above, the next time you login you do not have to perform steps 5 and 6.

Note: If you make an error entering your PIN you receive the message shown below. After three unsuccessful attempts at entering your PIN, the CAC is locked. See your local CAC issuer for assistance.

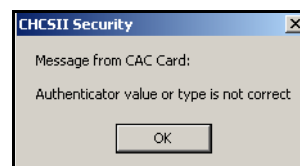


Figure 1-9: Warning Window

Note: If you want to leave the workstation, you may lock your session by pressing **Ctrl + Z** on your keyboard. Your session remains locked until you reinsert your CAC and PIN. During the time your session is locked, other users can use the workstation by inserting their CAC and PIN or by using normal login procedures.

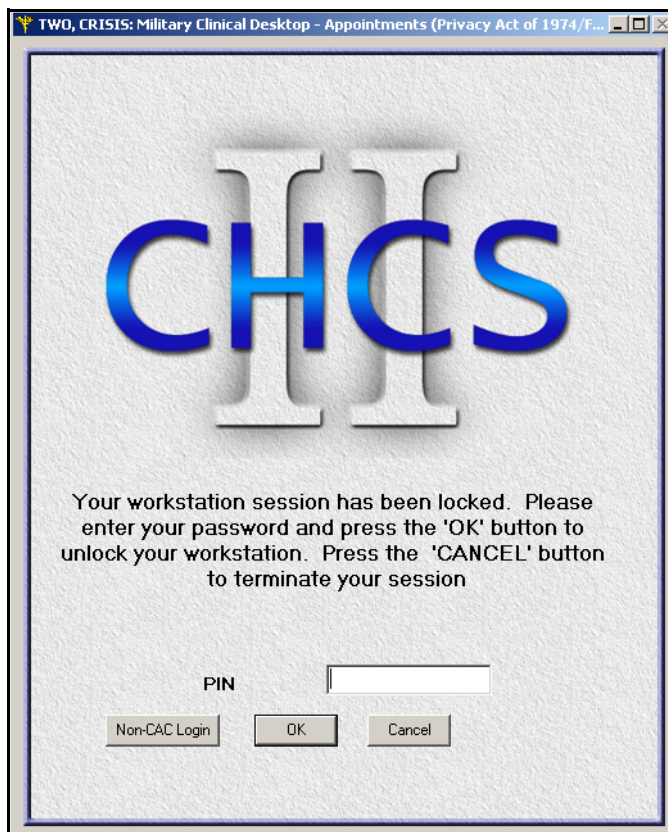


Figure 1-10: Log In Window

1.7 Changing the CHCS II Password

Upon 85 days after the creation of a new account or the last password change, the system prompts users to change their password within 5 days. This can be done directly through CHCS II. Changing the CHCS II password automatically changes the CHCS Verify code.

- If user does not change the password within 5 days, the account password is blocked. The Security Officer needs to unblock the account from the Web interface.
- If user does not log into CHCS II for 90 days, the system automatically places the account into dormant stage. The MTF must log a CHCS II Tier 1 ticket for assistance to remove an account from the dormant stage.

Note: According to the MHS Security Guidelines, the CHCS II password must meet the following criteria.

- Minimum of 8 and maximum of 20 characters
- Minimum of 1 numeric character
- Contain at least 1 of the following non-alphanumeric characters: !, @, #, \$, %, or &

- Mixture of case
 - It should not be a previously used CHCS Verify code
 - @ sign cannot be used in User ID or password
 - Passwords should not consist of words found in the dictionary
 - Should not be names, dates, etc., that are easy to guess
-

1.7.1 Changing CHCS II Password

Follow the steps below to change the CHCS II password:

1. Access the File menu and select **Change Password**.

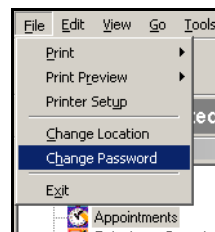


Figure 1-11: Change Password

2. Enter the existing password in the **Enter Old Password** field.
3. Enter the new password in the **New Password** field.

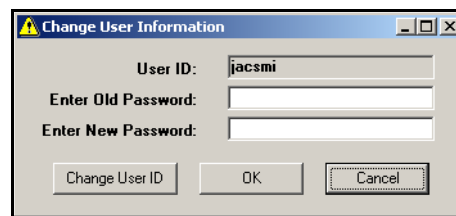


Figure 1-12: Change User Information Dialog Box

4. Click **OK**. A message displays stating that the password has been successfully changed.

1.7.2 Changing CHCS II User ID

Follow the steps below to change the User ID (username):

1. Access the File menu and select **Change Password**.
2. Click **Change User ID**.

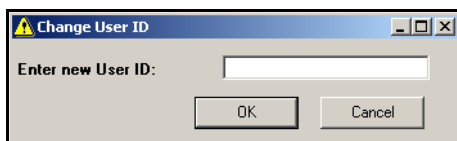


Figure 1–13: Change User ID Dialog Box

3. In the Change User ID dialog box, enter the new user ID in the **Enter New User ID** field.
4. Click **OK**. A message displays stating that the user ID has been successfully changed.

1.8 Exiting CHCS II

To exit CHCS II, do one of the following:

- Access the File menu and click **Exit**.

OR

- In the upper right-hand corner, click the 'X' as you would for any Windows application.

1.9 Protecting Sensitive Material

Do not provide data to persons contacting you by phone. Keep patient reports and confidential materials in a secure location. Report suspicious or malicious activity to your supervisor.

1.10 Protecting Your Assigned Username and Password

Change your password every 85 days. Create a password that avoids obvious words and combinations, such as your spouse's name, birthday, or telephone number. Do not use job titles. Never disclose your password to others. Memorize your password; do not write it down.

1.11 Protecting Your Workstation

Never leave your workstation unattended. Do not use password-protected screensavers—you must log off or lock CHCS II. You can lock your session by pressing **Ctrl + Z** on your keyboard. Your session remains locked until you enter your CHCS II password in the CHCS II Lockout screen or reinsert your CAC and enter your PIN. Position your workstation monitor so that it cannot be observed by passers-by. Never use a disk of unknown origin. Do not load unauthorized software onto the workstation. Make no changes to any workstation settings unless directed to do so by your supervisor.

1.12 Break the Glass Privileges

CHCS II provides authorized individuals with “Break the Glass” privileges to access sensitive patient information.

There are three types of users involving the “Break the Glass” privilege:

- Users who do not have the privilege at all.
- Users who do have the privilege.
- Users who already have the authority to see sensitive data and do not need the privilege.

If you have “Break the Glass” privileges, you receive a warning when trying to access sensitive data.

Click **Yes** to accept the warning message and view the sensitive results. CHCS II logs and audits this access.

If you do not want to accept the warning message, click **No**. You cannot view the sensitive information.

2.0 CHCS II NAVIGATION

2.1 Navigation Basics

The appearance and navigation functions within CHCS II are very similar to the appearance and navigation systems employed in other Windows operations. Many of the common icons for Windows are also used by CHCS II. For example, the icons in the upper-right corner of the screen are Minimize, Maximize, and Close. The Plus (+) and Minus (-) signs are called expand and collapse icons and are used to show that there are more folders above or below the folder that is currently being used. Also note that when a topic is selected, the icon text on the folder list becomes highlighted.

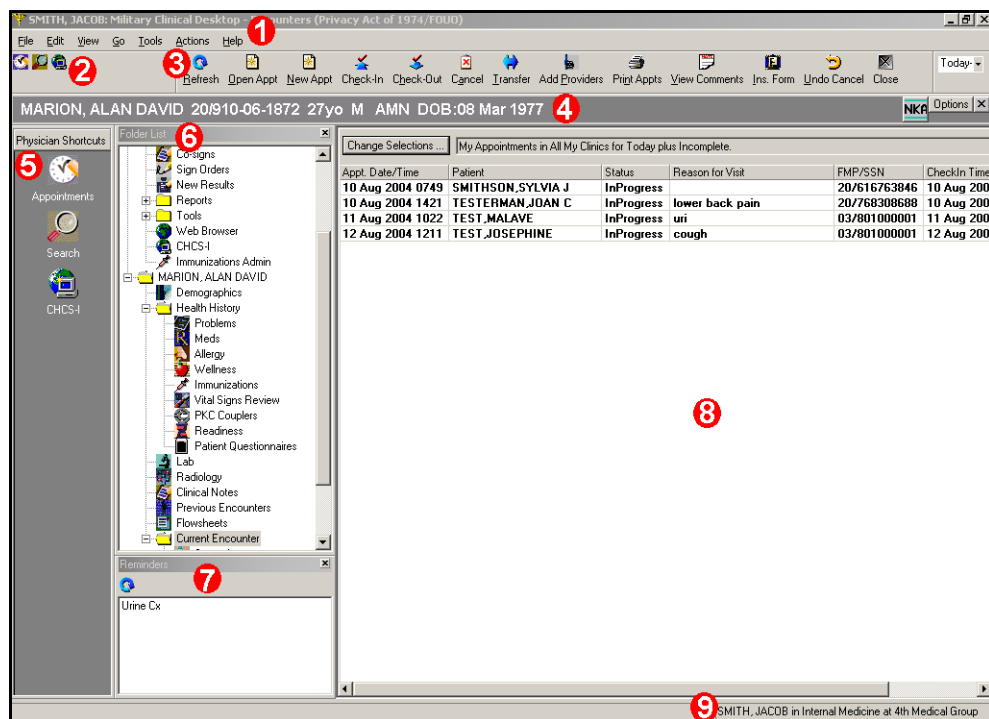


Figure 2-1: Military Clinical Desktop

1. **Menu Bar:** The Menu bar is located at the top of the application's user interface. It allows you to perform various functions that are Windows based (e.g., print, copy, paste), navigate to modules in CHCS II, and customize the appearance of CHCS II based on your user account.
2. **Tool Bar:** The Tool bar is located under the Menu bar and allows you to access CHCS II modules. You can customize the modules that display in the Tool bar to show words, icons, both, or nothing at all by accessing the View pull-down menu.
3. **Action Bar:** The Action bar is an extension of the Tool bar. It contains functionality that pertains to individual modules. As modules are opened and closed, the items on the Action bar change.

4. **Patient ID Bar:** The Patient ID bar is located under the Tool bar and Action bar. It includes Patient Demographic information and icons denoting Special Work Status, Command Interest, Command Security, allergy information and user alerts.
5. **Shortcuts:** The Shortcuts allow you to access CHCS II modules. Clicking on a particular icon or label opens the associated module. The Shortcuts can be customized to show words, icons, both, or neither by accessing the View pull-down menu.
6. **Folder List:** The Folder List displays icons pertaining to the modules that are on the desktop in an hierarchical manner. It allows all of the folders within the system to be seen. The Folder List can be hidden using the View pull-down menu.
7. **Reminders Pane:** The Reminders Pane displays a listing of Wellness Reminders that are due for the selected patient. If a patient encounter is opened, double-clicking on a reminder navigates you directly to the Reminders tab in the Assessment and Plan (A/P) module so that you can address the reminder.
8. **Workspace:** The Workspace displays the open module and is where most actions are performed.
9. **Status Bar:** The Status bar is located at the bottom of the application and shows details about the screen currently displayed. The Status bar can be hidden using the View pull-down menu.

2.2 Customizing the CHCS II User Interface

You can customize CHCS II to match how you navigate through and use the application. CHCS II allows you to display or hide the Tool bar, Action bar, Shortcuts, Folder List, and/or Status bar.

2.2.1 Viewing/Hiding Folders

Follow the steps below to view/hide folders:

1. Click **View** on the Menu bar. The View pull-down menu displays.
2. Click **Folders** to view or hide the Folder List. A checkmark indicates that the Folder List is viewable.

2.2.2 Viewing/Hiding Shortcuts

Follow the steps below to view/hide Shortcuts:

1. Click **View** on the Menu bar. The View pull-down menu displays.
2. Hover your mouse over **Shortcuts** to display the Shortcuts sub-menu and select either **Large Icons** or **Small Icons** to view or hide the Shortcuts.

2.2.3 Viewing/Hiding the Action Bar

Follow the steps below to view/hide the Action bar:

1. Click **View** on the Menu bar. The View pull-down menu displays.
2. Hover your mouse over **Action Bar** to display the Action Bar sub-menu and select one of the following:
 - **Icons:** Icons displays only icons on the Action bar.
 - **Text:** Text displays only text on the Action bar.
 - **Both:** Both displays icons and text on the Action bar.
 - **None:** None hides the Action bar.

2.2.4 Viewing/Hiding the Tool Bar

Follow the steps below to view/hide the Tool bar:

1. Click **View** on the Menu bar. The View pull-down menu displays.
2. Hover your mouse over **Tool Bar** to display the Tool Bar sub-menu and select one of the following:
 - **Icons:** Icons displays only icons on the Tool bar.
 - **Text:** Text displays only text on the Tool bar.
 - **Both:** Both displays icons and text on the Tool bar.
 - **None:** None hides the Tool bar.

2.2.5 Viewing/Hiding the Status Bar

Follow the steps below to view/hide the Status bar:

1. Click **View** on the Menu bar. The View pull-down menu displays.
2. Click **Status Bar** to view or hide the Status bar. A checkmark indicates that the Status bar is viewable.

2.2.6 Customizing the Tool Bar and Shortcut Options

The Tool bar is located below the Menu bar and allows you to access modules you customized to display in the bar. Module icons and/or text display, depending on whether or not they are patient-specific or encounter-specific. Modules that are added to the Tool bar are also added to the Shortcuts.

Follow the steps below to customize the icons:

1. On the **View** menu, point to **Tool Bar** and click **Customize** to open the Customize Toolbar window.
2. From the Available Toolbar Buttons picklist, select the module icon(s) you want to display in the Tool bar.

3. Click **Add** to add the selected module icon(s) to the Selected ToolBar Buttons picklist.

Note: You may drag and drop button icons within the Selected ToolBar Buttons picklist to determine the order of presentation on the Tool bar. The icons and/or text display according to whether they require a loaded patient record, open encounter, or neither.

4. Click **OK**.

2.3 Opening a Module

There are generally four ways to access individual modules.

- In the Folder List, click the icon associated with the module you want to open.
- On the Shortcuts bar, click the icon associated with the module you want to open.
- On the Tool bar, click the icon associated with the module you want to open.

Note: Icons on the Shortcuts and the Tool bar are only present if the desktop has been customized to include them.

- Access the Go pull-down menu from the Main menu bar and select the desired module. All other modules can be found under the Tools pull-down menu.

2.4 Closing a Module

There are three ways to close a module. It is best to close each module before opening a new one. The modules are opened one on top of the other and use unnecessary memory.

Perform one of the steps below to close a module:

- Use the Actions pull-down menu and click **Close**.
- On the Action bar, click **Close**.
- In the upper, right-hand corner of the Workspace, click **X**.

2.5 Startup Options

CHCS II allows you to determine the module you want to display when you login to the application. These modules are not patient-specific; therefore, you do not need a patient record loaded or an encounter open.

Follow the steps below to select the module you want to display when you login:

1. On the Tools menu, click **Startup Options** to open the Startup Options window.

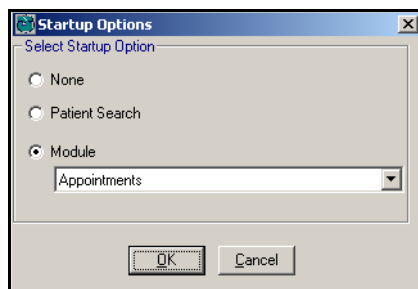


Figure 2-2: Startup Options

















2. Select one of the options:
 - **None:** A blank workspace is displayed when you login.
 - **Patient Search:** The Patient Search module is displayed when you login.
 - **Module:** A module selected from the drop-down list is displayed when you login.
3. Click **OK** to save the selection. The change takes effect with your next login.

2.6 Patient ID Bar

The Patient ID Bar is located under the Menu bar and includes patient demographic information and icons denoting Special Work Status, Command Interest, Command Security, allergy information and user alerts.

- Patient-specific information is displayed when a patient record has been selected.
- Work Status can be documented in the Screening, Demographics, or Disposition modules. The Work Status icons are only documented in CHCS II and do not interface with other systems.
- The Allergy icons are based on the entries from the Allergy module and entries in CHCS.
- Command Interest and Command Security information is pulled from CHCS and is displayed on the Demographics module.
- An alert icon is displayed if you have items needing your attention.

2.6.1 Patient ID Bar Icons

 Diving Status	 Flying Status
 Jumping Status	 Mobility Status
 Military Police Status	 Personal Reliability Program Status
 Presidential Support Program	 Submarine Status
 Patient Has Allergies	 Allergies Have Not Been Addressed
 No Known Allergies	 Command Interest Status
 Security Command Interest Status	 New Results
 Priority Results and Co-Signs	 Orders to Sign Icon Group

The Patient ID Bar icons display on the bar, if applicable to the patient or user.

2.7 CHCS Access

Some functions cannot be completed within CHCS II and need to be done in CHCS; scheduling future appointments is a good example. CHCS II does contain the functionality to connect directly to CHCS through a telnet session. This window is independent of CHCS II.

Follow the steps below to access CHCS:

1. In the Tools menu, select **CHCS-I Access** or click **CHCS-I** from the Folder List.
2. A KEA! session opens, allowing tasks to be completed. CHCS II automatically logs the user onto CHCS using the user's access and verify codes.
3. Close the KEA! session by clicking **X** in the top, right corner. When the confirmation window appears, click **Yes** to return to CHCS II.

2.7.1 In More Depth

CHCS II automatically logs you into CHCS using your access and verify codes. The CHCS verify code and CHCS II password are synchronized during the CHCS II Account Creation process. This synchronization process links your CHCS and CHCS II accounts.

3.0 FAILOVER OPERATIONS

3.1 Failover Operations Overview

Prior to the release of 838, CHCS II architecture utilized a central database, the Clinical Data Repository (CDR). Because of this architectural design, CHCS II was dependent on its ability to access the CDR. CHCS II clinical team members could not conduct basic patient services when the CDR was down or inaccessible due to a Wide Area Network (WAN) issue.

With the release of 838, CHCS II will implement a Local Cache architecture. The purpose of the Local Cache architecture is to provide CHCS II clinical team members with the ability to electronically document patient encounters in the event of a WAN or application outage between the CHCS host site and the CDR. A local cache server will be added at each host site that includes the Local Cache Database (LCD). During the documentation of an encounter, all data will be saved to the LCD. Once an encounter is signed, the encounter data are synced with the CDR.

Local Cache implementation consists of two main system modes: “normal mode” and “failover mode.” If the CDR, LCD, and CHCS are available, the system is in normal mode. If the CDR is unavailable, but the LCD and CHCS are available, the system is in failover mode.

During failover mode, the CHCS II client presents data from the LCD and CHCS, instead of the CDR. The change in the architecture allows clinical team members to continue to document existing encounters, as well as to create new encounters in a failover mode. Upon completion of the encounters in failover mode, the encounters will be queued for later submission to the CDR. Once connectivity has been restored, the completed encounters will be synced with the CDR automatically.

To ensure that the LCD contains pertinent clinical data in the case of failover, a nightly push occurs from the CDR to the LCD. The data in this push include application data, and patient data as well as user settings and immunization data.

- Application Data:
 - Provider information: list of valid providers/properties
 - Clinic information: list of valid clinics/properties
 - Clinic/provider relationships
 - Cosigners, etc.
 - Ancillary lists
- Patient-specific data are sent to the LCD for those patients with a scheduled appointment the following day:
 - Appointment information
 - Last four previous encounters
 - Problem list (problems only, no associated encounters or treatments [orders])

- User settings are also sent to the LCD:
 - Favorite lists
 - Desktop sizing
 - Folder list vs. buttons
 - Autocite/print options
 - Templates (S/O and encounter)
- Immunization data:
 - Lots/store information

Some modules are not supported in failover mode and will be unavailable. During failover mode, all modules that support failover mode will write their data to the LCD and/or CHCS.

Module	Supported	Not Supported
Appointments	•	
Alert Review	•	
Allergy	•	
Army Readiness		•
Assessment and Plan	•	
Clinical Notes		•
Consult Log		•
Co-signs	•	
Demographics	•	
Disposition	•	
Encounter Summary	•	
Flowsheets		•
Health History	•	
Immunizations	•	
Immunizations Admin		•
Labs	•	
List Management	•	
Meds	•	
New Results		•
Patient List		•
Patient Questionnaires		•
PKC Couplers		•
Previous Encounters	•	
Problems	•	
Questionnaire Setup		•
Rad	•	
Readiness		•
Reports		•
Rx Alternatives		•
S/O	•	
Screening	•	
Screening Notification		•
Sign Orders	•	
Telephone Consults	•	
Template Management		•
Vital Signs (Entry)	•	
Vital Signs (Review)	•	
Web Browser	•	
Wellness		•

Figure 3-1: Failover Mode Supported Modules

The Training System will not simulate failover operations, as it is a self-contained system.

3.2 Failover Mode

When connectivity with the CDR is lost, a warning dialog box appears when the user tries to perform an action that requires the CDR. The dialog box will inform the user of the network loss and will provide the user with the option to either retry connecting to the CDR by clicking **Retry**, or to exit the application by clicking **Exit**.

Note: The user is only permitted one attempt to restore the connection.

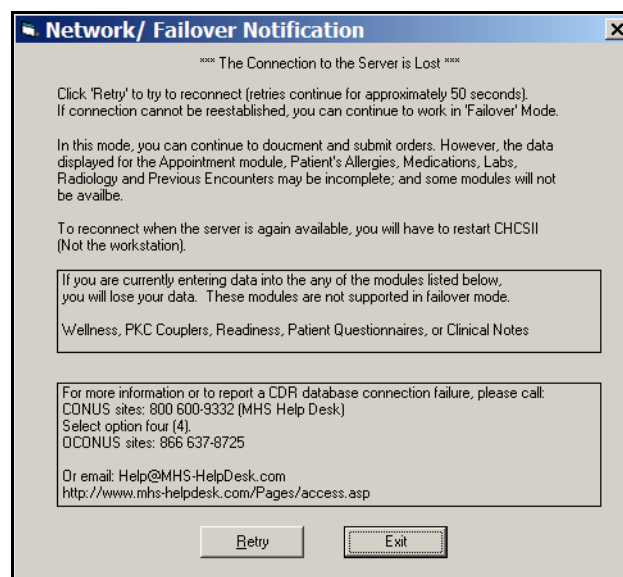


Figure 3–2: Network/Failover Notification Window

If the connection is re-established, the user can continue working in normal operations. If the connection cannot be re-established, the user is informed that CHCS II is currently in failover mode. The user can elect to either continue by clicking **OK**, or exit CHCS II by clicking **Exit**.

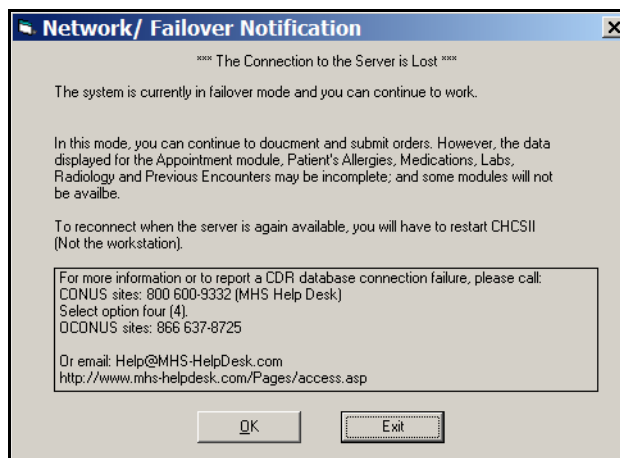


Figure 3-3: Network/Failover Notification Window

When CHCS II switches over to failover mode, the application will provide two visually distinct identifiers. The Title Bar will display “Failover Mode—Enterprise Data Not Available” and the Patient ID bar will be red. Additionally, modules that are not supported will not be visible in the Folder List, the Shortcuts, or the Go pull-down menu.

Note: If the user has modified their computer’s color scheme, the Patient ID bar color may not appear in red. It is recommended that users keep the default color scheme.

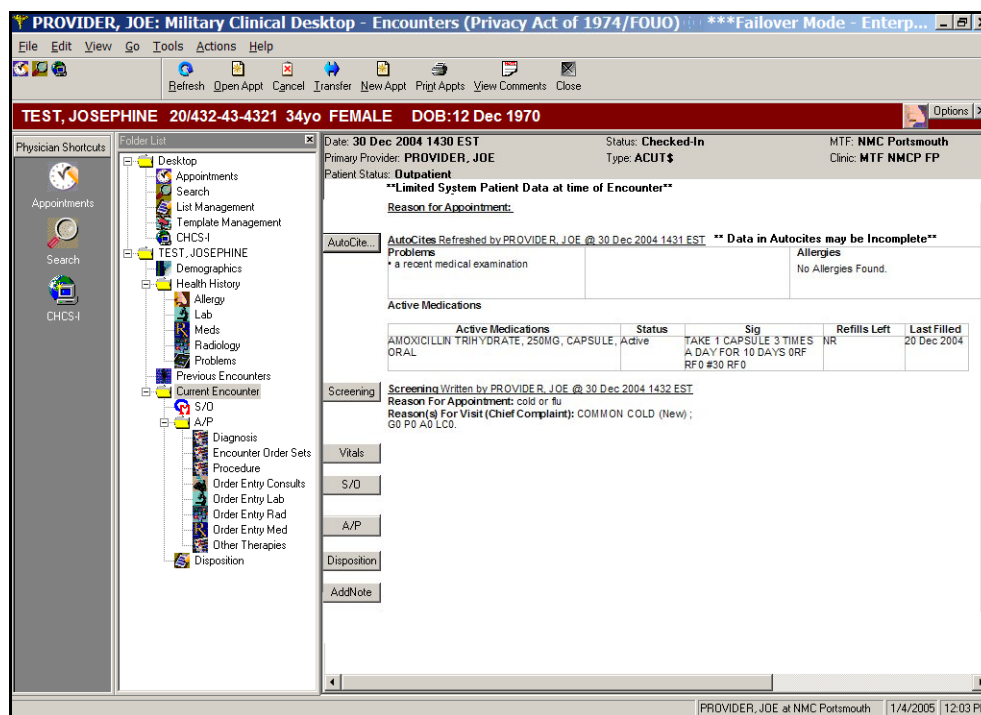


Figure 3-4: Military Clinical Desktop—Failover Mode

If the user selects to exit the application, encounter information is saved to the LCD and the signed encounter data are synced to the CDR when connectivity is restored.

3.3 LCD Failure

With the implementation of Local Cache, CHCS II is dependent on the LCD for both normal and failover operations. When there is a loss of connectivity with the LCD, CHCS II cannot operate. The system displays a dialog box informing the user that the connection to the Data Source is lost and CHCS II cannot continue to operate. Any data that had not been saved prior to this failure are lost. The user may click **Retry** once to try to reconnect or **Exit** to exit CHCS II.

Note: Users should follow MTF policies to determine how to proceed in this situation.

3.4 CHCS Failure in Failover Mode

With the implementation of Local Cache in failover mode, CHCS II is dependent on CHCS for certain functions. CHCS connectivity loss is detected when a module tries to connect with CHCS and is unable to do so. When connectivity is lost, the system will display the following message: “CHCS is currently unavailable.”

Any functions that require the availability of CHCS cannot be performed during this state. Since failover mode reads/writes appointment records to CHCS during failover, only the current encounter can be completed when CHCS connectivity is lost. Once the current encounter is completed, no other encounters can be created.

If connection with CHCS fails, the following modules or actions will be incomplete or unavailable:

- Alerts
- Allergies
- Appointments
- Consults
- Demographics
- Lab Order Entry
- Medication Order Entry
- New Appointment Sync
- New Results
- Patient Search
- Previous Encounters
- Rad Order Entry

- Telephone Consults
- Walk-in/Unscheduled Visits

Note: Users should follow MTF policies to determine how to proceed in this situation.

3.5 Failover Operations

All modules that support failover mode will write their data to the LCD and/or CHCS in failover mode. Data Sync will transfer any data changes (all ancillary patient data) to the CDR when the connection is restored. Any module that is not supported in failover mode will be unavailable.

If network connectivity is lost before the user logs in, the system will login the user in failover mode. A warning dialog box will inform the user of the network loss and will provide the user with the option to either Click **OK** to enter CHCS II in failover mode or click **Exit** to exit the application.

3.6 Failover Mode Supported Modules

Modules that are supported by Failover operations are broken into two categories: patient encounter data modules and ancillary patient data modules.

3.6.1 Patient Encounter Modules

Patient Encounter modules write their data to the LCD regardless of whether CHCS II is in normal or failover operations. After an encounter is signed, the data will be synced with the CDR. If the encounter is not signed, the data will continue to reside on the LCD and will not write to the CDR. During failover operations, signed encounters will be queued for later submission to the CDR when connectivity has been restored.

Patient Encounter modules:

- Current Encounter Summary (SF600)
- Screening
- Vital Signs
- S/O and A/P
- Disposition
- Co-Signs

Patient Encounter module functionality is not affected by failover operations, with the noted exceptions.

3.6.1.1 Current Encounter Summary (Electronic SF600)

“**Limited Patient Data at Time of Encounter**” displays in the top of the SF600, and the warning “**Data in Autocites may be Incomplete**” displays on the first line of the AutoCites section in the SF600.

If the patient has a scheduled appointment, AutoCites display Active Problems, CHCS Allergies, CHCS Active Dispensed Medications, CHCS Labs, CHCS Rads, and Active Family History.

If the patient is a walk-in/sick call patient for that day, no historical information will be available except for what comes from CHCS. AutoCite will only display Allergies, Medications, Laboratory, and Radiology results from the local CHCS host. Active problems, active family history, questionnaires, and historical vitals are not displayed.

3.6.1.2 Screening

The Due Reminders tab is unavailable in failover mode. Special Work Status is disabled during failover operations, and cannot be edited in failover mode.

3.6.1.3 Vital Signs

The Review tab will only display any associated vital signs from the last four previous encounters.

3.6.1.4 S/O and A/P

Templates from the user's favorites list are available for selection from the template drop-down list. If the user had previously loaded a Clinic, MTF, or Enterprise template, its contents become the Current Encounter Template. During failover mode operations, the embedded Current Encounter Template will continue to be available, only for the specific encounter. No other Encounter templates are available during failover mode operations.

Submitted orders are sent to CHCS and are also saved to the LCD as part of the encounter data.

3.6.1.5 Disposition

Special Work Status is disabled during failover operations, and cannot be edited in failover mode.

3.6.2 Ancillary Patient Data Modules

Ancillary patient data modules will have limited functionality in failover mode. In normal operations, the ancillary patient data modules read/write their data to and from the CDR directly. During failover operations, the ancillary patient data modules read/write their information from/to the LCD and/or CHCS instead of the CDR.

Ancillary patient data modules:

- Alert Review

- Allergy
- Appointments
- Demographics
- Health History
- Immunizations
- Lab Results
- List Management
- Medications
- Previous Encounters
- Problems
- Rad Results
- Telephone Consults

3.6.2.1 Alert Review

Only CHCS non-Order Entry alerts will be available in failover mode. CHCS II-specific alerts are not supported and will not display.

3.6.2.2 Allergy

During failover mode, reactions to previously documented allergies are displayed in the comments field.

Patient allergy information can be added, edited, deleted, or verified in failover mode. The data are saved to CHCS. Although new allergies can be added in failover mode, the new allergy reactions cannot be added directly. CHCS does not have a field for reactions, so the reaction is not saved to CHCS. Instead, reactions should be documented in the Comments field. When connection to the CDR is restored, CHCS only sends the new allergy and the comment field to the CDR. When normal operations are restored, users can edit and modify those allergies that were added during failover operations.

3.6.2.3 Appointments

The Appointments module reads and writes data from/to CHCS. Only scheduled CHCS appointments will be available, along with all In Progress, Incomplete appointments, telcons and encounters needing cosignatures. Users should set the Appointments module properties to view both appointments and telcons.

Walk-in appointments and telcons can be created in failover mode; however, patient searches will be limited to CHCS. After the appointment or telcon has been created, the encounter data are saved to the LCD.

3.6.2.4 Demographics

Patient demographic information can only be reviewed in failover mode. Special Work Status is disabled during failover operations, and cannot be edited in failover mode.

3.6.2.5 Health History

The Health History module will only display modules that are supported in failover mode.

3.6.2.6 Immunizations

Immunizations can still be delivered to a patient and documented in the Immunizations module. The lot/store data are saved to the LCD. The Vaccine History tab will display only the historical vaccines that were entered during failover mode.

3.6.2.7 Lab Results

Only the Lab results available from the CHCS host for the patient can be reviewed. The filtering criteria available during this mode will be limited to the Sliding Time Range and Specific Time Period (date range) options on the Time Search window.

3.6.2.8 List Management

The List Management module can be reviewed, edited, and added to in failover operations; however, any changes made will not be synced back to the CDR. When the CDR connection is restored, the CDR-based settings will be utilized.

3.6.2.9 Medications

Medications can only be reviewed in failover mode. Over-the-Counter (OTC) medications cannot be documented in the Meds module during failover operation because CHCS does not have any fields for OTC medications.

3.6.2.10 Previous Encounters

The last four previous encounters will be available for viewing during failover mode. A previous encounter can be appended or amended providing it was completed in the user's current facility.

3.6.2.11 Problems

Health Care Maintenance and Dental Readiness are unavailable. The user can still add, edit, or review problems. The changes will be saved to the LCD.

3.6.2.12 Rad Results

Only the Radiology results available from the CHCS host for the patient can be reviewed. The filtering criteria available during this mode will be limited to the Sliding Time Range and Specific Time Period (date range) options on the Time Search window.

3.6.2.13 Telephone Consults

In failover mode, all telephone consults will be displayed in the Appointments module. The Appointments module will display all incomplete/in-progress telcons from the current day and all previous incomplete telcons. The user is able to create new telcons during failover mode operations.

Note: When creating new telcons, your patient search will be limited to your CHCS facility only.

Note: Although Microsoft corporation's Internet Explorer (IE) displays as a module in CHCS II, its web connection is completely unrelated to CHCS II. It is not affected by either CHCS II normal or failover operations.

3.6.3 Unsupported Modules

During transition to failover mode, modules that are not supported during failover operations close without saving. Any data that had been written to unsupported modules since the last save are lost and the module is removed from the Toolbar, Shortcuts list, and Folders list. The user will be unable to access any unsupported modules in failover mode. To minimize the potential impact, users are encouraged to save their work and close modules that are not being used.

The following modules are not supported in failover mode:

- Army Readiness
- Consult Log
- Clinical Notes
- Flowsheets
- Immunization Admin
- New Results
- OB Summary
- Patient List
- Patient Questionnaires
- PKC Couplers

- Questionnaire Setup
- Readiness
- Reports
- Rx Alternatives
- Screening Notification
- Sign Orders
- Template Management
- Vital Signs (Review)
- Wellness

3.6.3.1 New Results

Although the New Results module is unavailable in failover mode, users can view new results by clicking the **CHCS I** icon in the Folder List to launch a Telnet session into CHCS.

3.6.3.2 Template Management

Although the Template Management module will not be available during failover mode operations, encounter templates from the user's My Favorites list will be selectable from the drop-down lists in the S/O and A/P modules. Additionally, the contents of encounter templates that have been loaded into a specific encounter become embedded as a part of that encounter and renamed as the Current Encounter Template. The contents of the Current Encounter Template will continue to be available for that specific encounter when the system goes into failover mode operations.

3.7 User Configuration Data

User configuration data (i.e., Folder list, Shortcuts list, Desktop sizing, AutoCite/print options) can be changed in failover mode; however, these changes only remain in effect during the current failover mode event. Configuration data changes are not written back to the CDR when connectivity is restored. When the CDR connection is restored, CHCS II will load the configuration data saved in the CDR.

4.0 WORK FLOWS

4.1 Basic Front Desk Clerk Workflow

CHCS II Front Desk Clerk tasks typically include managing the appointments and demographic information. Other tasks can be included depending on the clinic and role of each individual clerk.

The basic front desk workflow may be:

1. Access the Appointments module.
2. Check-in a scheduled appointment.
3. Create a new walk-in appointment.
4. Review the demographic information and make any modifications.

Other modules the Front Desk Clerk can use include:

- Telephone Consults
- PKC Couplers
- Web Browser

4.2 Basic Support Staff Workflow

CHCS II support staff tasks typically include entering the reason for visit in the Screening module and documenting the vital signs. Other tasks can be included depending on the clinic and role of each individual.

The basic support staff workflow may be:

1. Access the Appointments module.
2. Double-click the appointment from the list.
3. From the Patient Encounter module, click **Screening** and enter the reason for visit.
4. On the Action bar, click **Vital Signs**. Enter the vital signs.
5. Close the Vital Signs module and the Patient Encounter module.
6. Return to the Appointments module to wait for the next patient.

Other modules the support staff can use include:

- Wellness
- Web Browser
- Allergy
- Clinical Notes
- Health History

- Reports
- Immunizations
- Medications
- Readiness

4.3 Basic Provider Workflow

CHCS II Provider tasks typically include selecting an encounter template, documenting the subjective and objective (S/O) portion, completing the assessment and plan (A/P), and ordering appropriate medications and laboratory and radiology tests. Other tasks can be included depending on the clinic and role of each individual provider.

The basic provider workflow may be:

1. Access the Appointments module.
2. Double-click the desired appointment.
3. Click **S/O**.
4. Select an encounter template to load into the encounter.
5. Document the exam using the various tabs from the S/O module.
6. Click **A/P**. Document the diagnosis and procedures.
7. Order radiology and/or laboratory tests, medications, or consults. Associate any procedures and/or orders with a diagnosis.
8. Click **Disposition**.
9. Complete the disposition.
10. Click **Sign**.
11. Enter the password and click **Sign**.

Other modules the Provider can use include:

- Alert Review
- Co-Signs Required
- Medications
- List Management
- Laboratory
- Patient List
- Radiology
- Flowsheets
- Problems
- Web Browser
- Consult Log

- Reports
- Previous Encounters
- Clinical Notes
- New Results
- Order Sets
- Sign Orders

5.0 ALLERGY

5.1 Allergy Overview

The Allergy module maintains current allergy information for a patient. This information is pulled from CHCS and synchronized at different times during the encounter documentation. The Allergy module allows information to be stored using data from the Healthcare Data Dictionary (HDD). A common list of allergens can also be created to make entering data more convenient.

The screenshot shows a software window titled "227-44-1002 44yo F DOB:04 Apr 1960". At the top, there is a menu bar with icons for "Add", "Edit", "Delete", "Refresh", and "Close". Below the menu bar, there are two checkboxes: "No known allergies" (unchecked) and "Verified This Encounter" (unchecked). The main area contains a table with the following data:

Allergen	Reaction	Onset Date	Info Source	Entered By	Comments
Aspirin	Rash	29 Sep 2004	Patient	PROVIDER, TERRY	
PEANUT OIL (PEANUT OIL)	Unknown	21 Sep 2004	Unknown Source of Info	CHCS	

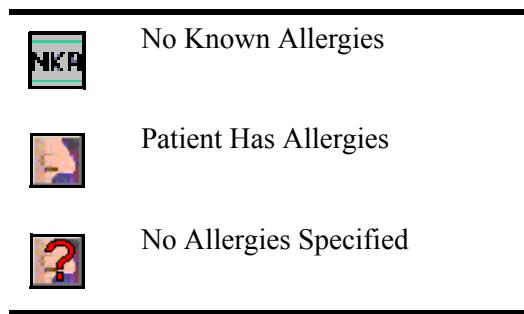
Below the table, there is a form with the following fields:

- Allergen: Aspirin
- Onset Date: 29 Sep 2004
- Entered By: PROVIDER, TERRY
- Reactions: Rash
- Info Source: Patient
- Comments:

Figure 5–1: Military Clinical Desktop—Allergy Module

5.1.1 In More Depth

CHCS II uses three different Allergy icons to indicate the patient's allergy status. These icons appear on the Patient ID bar. Clicking on the allergy icon opens the Allergy module.



Allergy information is passed between CHCS and CHCS II every time there is a change to allergy information. Any changes in CHCS are loaded into the CDR and any changes in CHCS II are sent back to CHCS. Allergy synchronization occurs when a new unscheduled visit is created in CHCS II and when the Allergy module is opened. This ensures that the diagnoses and orders completed in each patient encounter are made with an awareness of the patient's current allergy profile. Clinical team members need to be aware of the patient's allergy profile when prescribing medications and administering immunizations; thus, allergy information is also available in the Medications and Immunizations modules.

If the patient has no known allergies, the Allergy module is blank except for the checkbox.

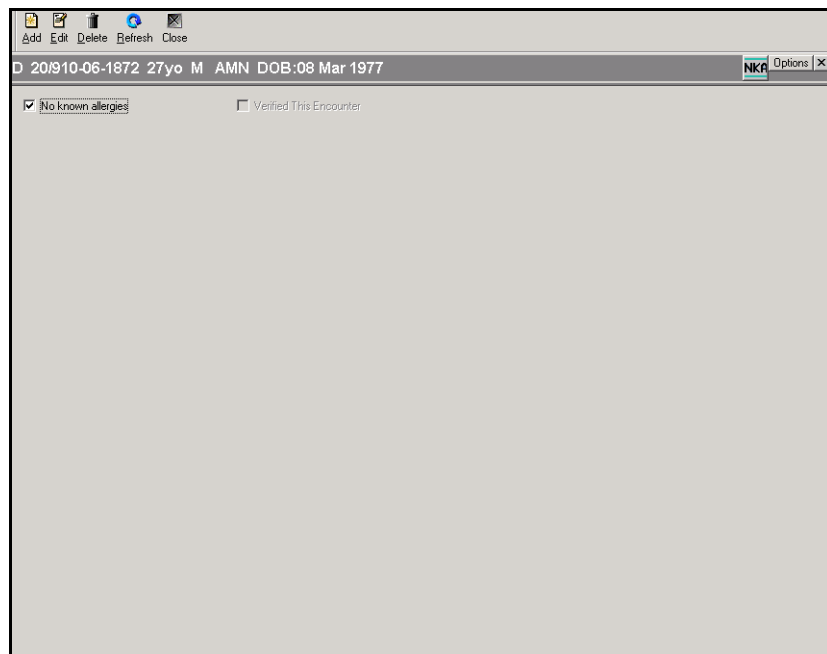


Figure 5–2: Allergy Module

Allergy information should be verified during every encounter. The Verified This Encounter checkbox is not active in the Allergy module when opening the module through the Allergy icon. The checkbox is active when the Allergy module is opened through the Screening module.

5.2 Creating a Common List of Allergens

The Properties window associated with Allergies allows for the creation of a list of allergens most often used. This list populates the drop-down list in the **Allergen** field on the New Allergy window. This eliminates the need to conduct a lengthy search. A default list is pre-populated when CHCS II is deployed; however, clinical team members can create their own list.

Follow the steps below to create a common list:

1. Click **Options** on the Allergy module. The Properties window opens.

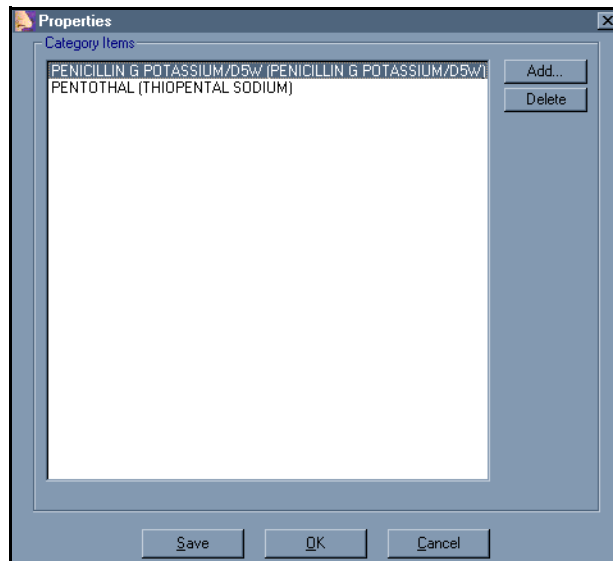


Figure 5-3: Allergy Module Properties Window

2. Click **Add**. The Add to Common List Items window opens.

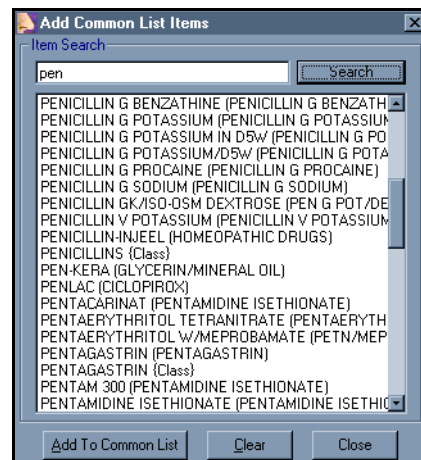


Figure 5-4: Add to Common List Items Window

3. Enter at least the first two letters of the allergen to be added.
4. Click **Search**. The search results are listed.

5. Select the desired item(s).
6. Click **Add to Common List**. Continue to add allergies to the list until all allergens you want have been selected.
7. Click **Close**. The Properties window displays the selected allergens.
8. Click **Save**.

Note: This list is combined with the pre-populated default list. Select the allergen and click **Delete** from the properties window to delete an allergen from the list.

5.3 Adding an Allergy

Clinical team members can add allergy information to a patient record through the Allergy module. If a patient has no allergies, the No Known Allergies checkbox is selected. If there is no allergy information for the patient, the No Known Allergies checkbox is available for selection.

Follow the steps below to add a new allergy:

1. Click **Add** on the Action bar. The New Allergy pane opens.

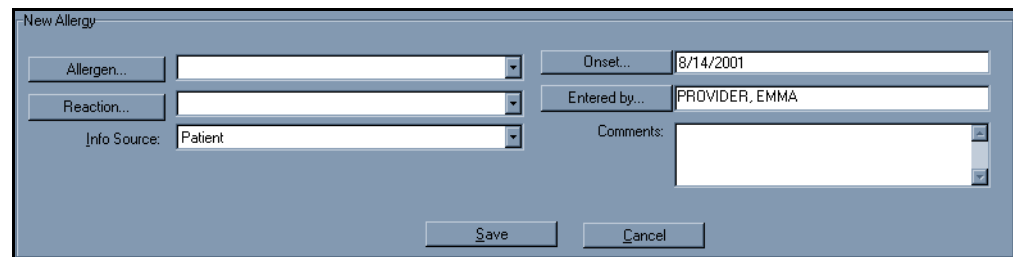


Figure 5-5: New Allergy Pane

2. Click **Allergen**. The Health Care Data Dictionary window opens, allowing you to search and add allergens.
3. Enter the allergen in the search field and click **Search**.
4. Select the desired allergen from the search results and click **OK**. You are returned to the New Allergy window with the selected allergen in the field.

Note: The allergen can also be selected from the common list of allergies. Access the list by opening the Allergen drop-down list.

5. Click **Reaction**. The Health Care Data Dictionary window opens, allowing you to search and add reactions.
6. Enter the reaction in the search field and click **Search**.

7. Select the desired reaction from the left column and click **Add>>** to move it to the right column. Search for and move additional reactions, as needed.
8. Click **OK**. You are returned to the New Allergy window with the selected reaction in the field.

Note: The reaction can also be selected from the common list of reactions. Access the list by opening the Reaction drop-down list.

9. Enter the appropriate information in the following fields:
 - **Info Source:** The Info Source is set by default to Patient and can be changed by selecting a different source from the drop-down list.
 - **Onset:** Enter a date in the date field (mm/dd/yyyy) to change the onset date (defaults to current date), or click **Onset** to use the Calendar.
 - **Entered By:** Click **Clinician** to open the Clinician Search window to change the associated clinician (defaults to clinician currently logged in), which allows a clinician to be selected.
 - **Comment:** In the Comment area, type any needed notes.
10. Click **Save**. The new allergy is added to the patient's list of allergies.

Note: In some instances, the exact allergen is not included in the HDD. In this case, search for and select the allergen **Other {class}**. On the New Allergy window, use the comments field to state the exact allergen.

5.4 Editing an Allergy

Follow the steps below to edit an allergy:

1. Select the allergy to be modified.
2. Click **Edit** on the Action bar. The Edit Allergy pane opens.

The screenshot shows the 'Edit Allergy' window. It contains several input fields and buttons. The 'Allergen...' field is a dropdown menu showing 'SALT PETER (POTASSIUM NITRATE)'. The 'Reaction...' field is a dropdown menu showing 'Unknown'. The 'Info Source:' field is a dropdown menu showing 'Unknown Source of Info'. The 'Onset...' field is a text box containing '5/3/2002'. The 'Entered by...' field is a text box containing 'DOCTOR, DAVID'. Below these fields is a large text area for 'Comments:'. At the bottom of the window are two buttons: 'Save' and 'Cancel'.

Figure 5-6: Edit Allergy Pane

3. Update the appropriate information in the following fields:
 - Reaction
 - Info Source

- Onset
- Entered by
- Comments

Note: The **Allergen** is not editable.

4. Click **Save**.

5.5 Deleting an Allergy

Follow the steps below to delete an allergy:

1. Select the allergy on the Allergy module.
2. Click **Delete** on the Action bar.
3. At the Confirm Deletion prompt, click **Yes**.

5.6 Verifying Allergies

Allergy information should be verified during every encounter. The verification of the allergy information, though, can only be done through the Screening module with an open patient encounter. The documentation of this process is written onto the electronic SF600 and becomes part of the medical record.

Follow the steps below to verify a patient's allergies:

1. In the Screening module, click **Verify Allergy** on the Action bar. You are transferred to the Allergy module.
2. Verify the patient's allergies in the Allergy module and select the **Verified This Encounter** checkbox.
3. Click **Close** on the Action bar to return to the Screening module.

☐ No known allergies ☒ Verified This Encounter

Allergen	Reaction	Onset Date	Info Source	Entered By	Comments
Penicillins	Rash	3/17/1962	Patient	NURSE, KAREN	

Allergen: Penicillins

Onset Date: 3/17/1962 Entered By: NURSE, KAREN

Reactions: Rash

Info Source: Patient

Comments:

Figure 5–7: Verify Allergies Pane

6.0 ALERT REVIEW MODULE

6.1 Alert Review Overview

The Alert Review module displays items that need immediate attention. It lists both primary end user and surrogate end user alerts. A surrogate end user is authorized to act on behalf of another end user. Unresolved alerts are in bold text and resolved alerts are in regular text. The gray and yellow colored alert icon in the patient ID bar signifies that an encounter needs to be cosigned, critical results and priority results. The blue and white colored alert icon signifies modified encounters, new results and orders to be signed.

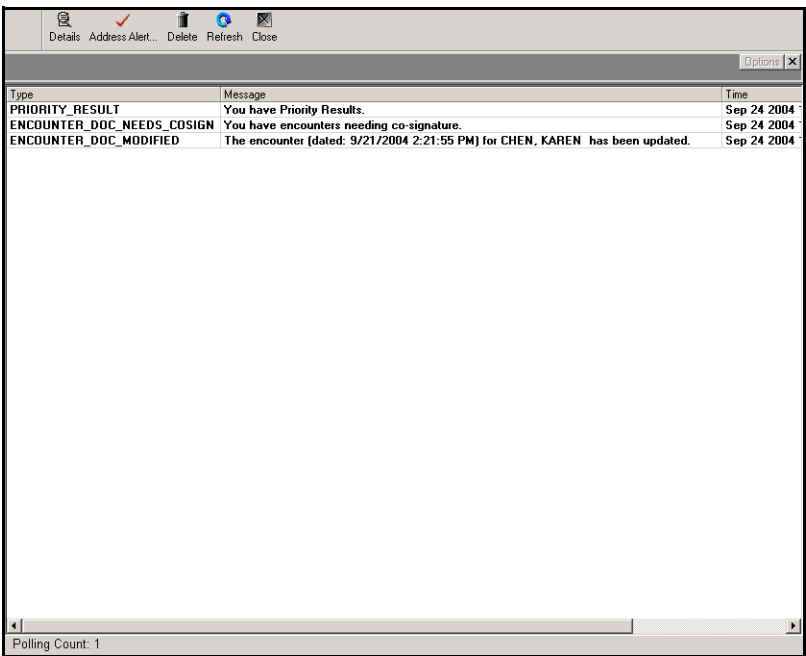


Figure 6-1: Military Clinical Desktop—Alert Review Module

6.1.1 In More Depth

An alert must be resolved within the module in which it resides.

New Result and Priority Result Alerts display as a result of actions performed in CHCS (such as lab tests). Priority Result Alerts are New Result Alerts that contain abnormal findings.

Types of Alerts:

- Encounter Doc Needs Co-signature
- You have priority results
- You have New Results

- Encounter Coding Information Has Modified
- Orders to Sign
- Mismatch ADM Coding

An alert icon is displayed on the Patient ID bar when a user has an alert. Two alert icons exist, depending on the types of alerts. The gray and yellow colored alert icon signifies that an encounter needs to be co-signed and priority results. The blue and white colored alert icon signifies modified encounters, new results and orders to be signed.

If an order needs to be signed, an additional icon displays on the Patient ID bar next to the Alert icon.

Multiple ADM alert types are triggered when coding differences are detected between CHCS and CHCS II based on factors such as ICD-9 code mismatches or secondary Provider errors. When addressing an ADM alert, a dialog box directs the Provider to go to the previous encounters for the patient and update the encounter in question.

6.2 Addressing an Alert

The primary end user or the surrogate end user can address an alert. If the primary end user addresses an alert, it is automatically removed from the list of alerts upon resolution. An alert resolved by the surrogate end user remains on the primary end user's list of alerts until the primary end user deletes it. Alerts that have not been addressed are indicated in bold text and alerts that have been addressed are indicated in plain text on the alerts list. An alert must be resolved within the module in which it resides. If, for example, you select a modified encounter alert to address, you are navigated directly to the relevant encounter in the Previous Encounters module.

Follow the steps below to address an alert:

1. Select the bolded alert.
2. Click **Address Alert** on the Action bar. The module containing the alert opens.
3. Address the alert by completing the tasks associated with the alert.
4. Click **Close**. The alert can now be deleted from the list.

6.3 Addressing New and Priority Result Alerts

New Result and Priority Result Alerts display as a result of actions performed in CHCS (such as lab tests). Priority Result Alerts are New Result Alerts that contain abnormal findings.

Follow the steps below to address new and priority result alerts:

1. Select the alert.
2. Click **Address Alert** on the Action bar. The Lab or Rad module opens, depending on the alert.
3. Select the **New Result** you want to review.

4. Either save or delete the result.
5. Click **Close** on the Action bar to return to the Alert Review module.

6.4 Deleting an Alert

Follow the steps below to delete an alert:

1. Select the alert.
2. Click **Delete** on the Action bar.

6.5 Viewing Details of an Alert

Follow the steps below to view details of an alert:

1. Select the desired alert.
2. Click **Details** on the Action bar. The Alert Details window opens.

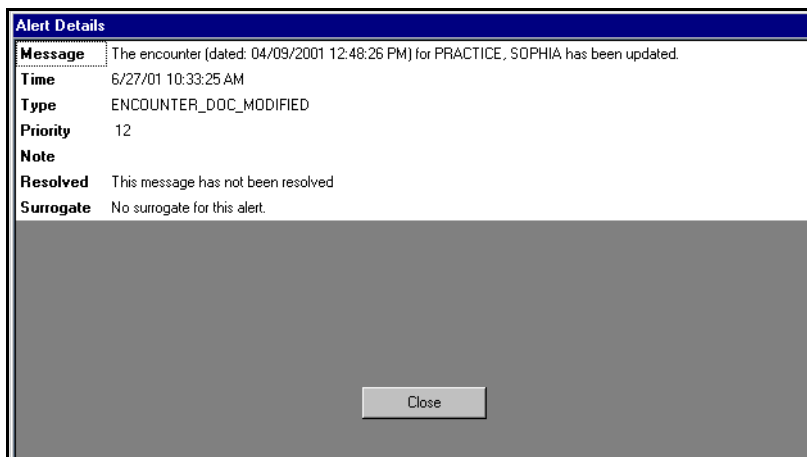


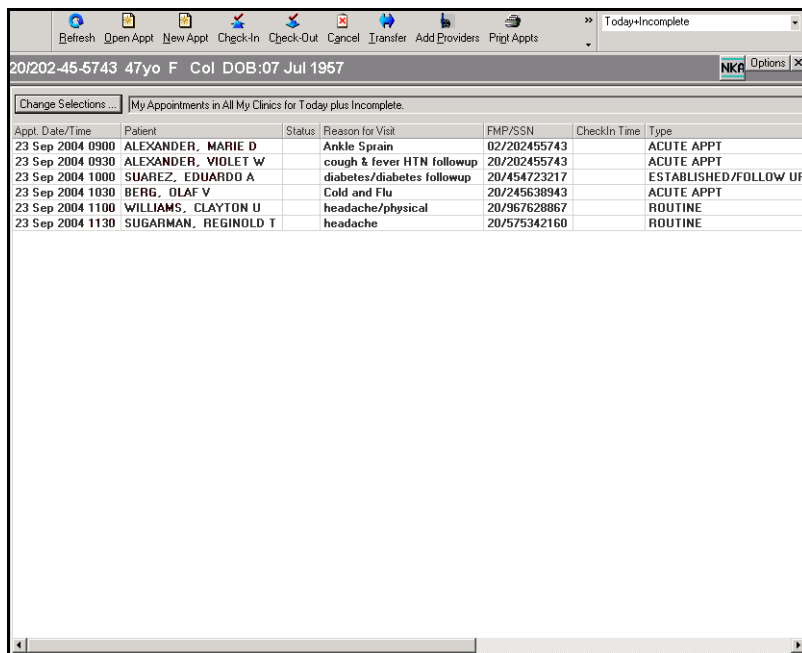
Figure 6–2: Alert Details Window

3. Review the detailed information on the selected alert.
4. Click **Close**.

7.0 APPOINTMENTS

7.1 Appointments Overview

The Appointments module enables appointments that have been created in both CHCS and CHCS II to be viewed according to clinics, providers, dates, or statuses. Appointments can be selected to check in, transfer, cancel, and checkout. Only unscheduled visits (walk-in, sick call) and telephone consults can be created in CHCS II. Scheduled appointments are still created in CHCS and then uploaded to CHCS II, real-time, along with appropriate patient information.



Appt. Date/Time	Patient	Status	Reason for Visit	FMP/SSN	CheckIn Time	Type
23 Sep 2004 0900	ALEXANDER, MARIE D		Ankle Sprain	02/202455743		ACUTE APPT
23 Sep 2004 0930	ALEXANDER, VIOLET W		cough & fever HTN followup	20/202455743		ACUTE APPT
23 Sep 2004 1000	SUAREZ, EDUARDO A		diabetes/diabetes followup	20/454723217		ESTABLISHED/FOLLOW UP
23 Sep 2004 1030	BERG, OLAF V		Cold and Flu	20/245638943		ACUTE APPT
23 Sep 2004 1100	WILLIAMS, CLAYTON U		headache/physical	20/967628867		ROUTINE
23 Sep 2004 1130	SUGARMAN, REGINOLD T		headache	20/575342160		ROUTINE

Figure 7-1: Military Clinical Desktop—Appointments Module

7.1.1 In More Depth

The Appointments module is comprised of several columns that can be re-arranged by clicking and dragging the columns with your mouse. The columns include the following:

- **Appt. Date/Time:** The date and time of the appointment.
- **Patient:** The name of the patient.
- **Status:** The status of the appointment (the location of the appointment in the clinical workflow—checked-in, waiting, in progress...).
- **Reason for Visit:** The reason for the patient visit.
- **FMP/SSN:** Family Member Prefix/Social Security Number.

- **Checkin Time:** The time the patient is checked in.
- **Type:** The appointment type.
- **Classification:** The status of the patient (outpatient or inpatient).
- **Home Phone:** The patient's home phone number.
- **Work Phone:** The patient's work phone number.
- **Comment:** Comments about the appointment.
- **Encounter:** A unique system generated ID that helps to track encounters.
- **Checkout Time:** The time the patient checks out. This is entered if the Check-Out option is used.
- **Appt IEN:** A unique ID generated by CHCS for an appointment that is unique for each MTF.
- **Appt ID:** A unique ID generated by CHCS for an appointment that is unique for each MTF.

The Appointments module is the default module that opens upon login. Most clinical team members use this module as a 'home base.' The individual appointment statuses can alert the team members as to where the patients are in the clinical workflow. For example, if an appointment has a status of checked-in, the support staff knows that the patient is ready to be screened. Statuses include the following:

- **Pending (blank field):** CHCS scheduled appointment that has not been checked-in
- **Checked-in:** The front desk has checked-in the patient and the patient is ready for screening
- **Waiting:** The screening is complete and the patient is waiting for the provider
- **In Progress:** A clinical team member has opened the S/O, A/P, or disposition module
- **Complete:** The encounter has been signed.
- **Updating:** The signed encounter is being updated
- **Updated:** The signed encounter has been updated and re-signed
- **Needs Co-signature:** The encounter has been signed but is awaiting co-signature

Once an appointment is created, checked in, or canceled, CHCS II sends the appointment status of Kept back to CHCS. Because of this, appointments should not be modified in the End of Day processing in CHCS.

7.2 Setting the Properties of the Appointments Module

The Appointments Search Selections window is used to filter appointments by clinic, provider, date and status. Once selections are made, they can be set as the default settings or for the current session only. The user can change the status that is being

viewed without using the Appointment Search Selections dialog box. A filter drop-down list can be accessed from the Appointments module.

The Appointment Search Selections window is also used to set new column order defaults. First, rearrange the column order by dragging the column by the column header.

Follow the steps below to set the properties of the Appointments module:

1. On the Appointments window, click **Change Selections**. The Appointment Search Selections window opens.

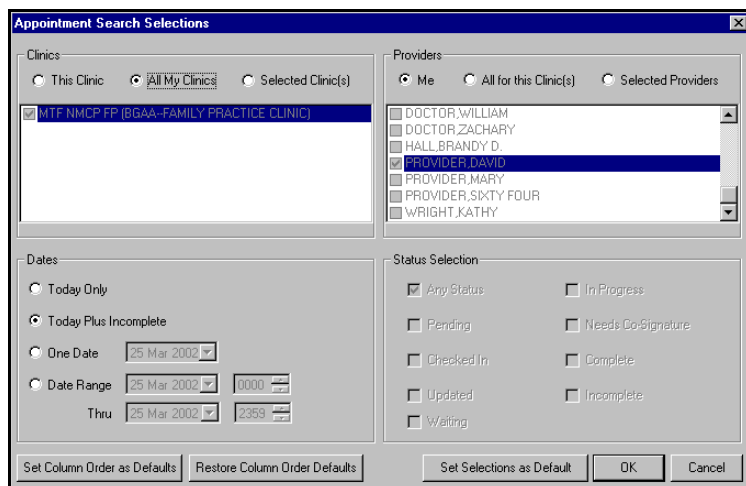


Figure 7–2: Appointment Search Selections Window

2. In the Clinic area, select the clinic(s) you want to view. If you select the **Selected Clinics** option, select the applicable clinic(s) from the list.
3. In the Provider area, select the provider(s) you want to view. If you select the **Selected Providers** option, select the applicable provider(s) from the list.
4. In the Dates area, select the appointment search date. If you select the **Date Range** option, select the applicable date range(s) from the drop-down list.
5. In the Status Selection area, select the appointment search status.
6. Click **Set Selections as Default**. The settings are now your default settings for the Appointment module. All appointments meeting the above criteria are listed on the Appointments module.

Note: To set the order of the columns, click **Set Column Order as Default**.

Tip:

It is recommended to set the date filter to Today Only. This will prevent the appointment list from showing appointments created prior to the implementation of CHCS II.

Tip:

The settings of the default view will primarily depend on your role. Front Desk Clerks and Support Staff generally view appointments for all clinics and all providers who are on duty on the given day. Providers usually set the filter to view assigned appointments for all clinics.

7.3 Filtering the List of Appointments

The list of appointments can be filtered by selecting a filter from the drop-down list in the upper-right corner of the workspace.

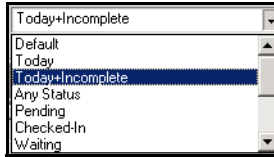


Figure 7–3: Appointments List Filter

This filter assumes the provider and clinic settings from the default filter and only changes based on the selection made. Changing the filter here only changes the view of the appointments for this session. When you open another module and then return to the Appointments module, the view is based on the default settings, set through the Change Selections button. Options include the following:

- **Default:** The Appointments filter default is set by clicking **Change Selections** and selecting the desired options. Click **Set Selections as Default** and then click **OK** to save the selections as default.
- **Today:** Appointments for today only.
- **Today + Incomplete:** Appointments for the present day and all appointments that have a status of incomplete that fall within the selection made in the **Dates** field on the Appointment Search Selections window.
- **Any Status:** All appointments regardless of their status that fall within the selection made in the **Dates** field on the Appointment Search Selections window.
- **Pending Only:** Appointments that have a status of pending, which means they have not been checked in yet and meet the date criteria in the Appointment Search Selection window.
- **Checked In:** Appointments that have been checked in and meet the date criteria set in the Appointment Search Selections window.
- **Waiting:** Appointments for which the patient has been checked in but is waiting to be seen by the provider and meet the date criteria set in the Appointment Search Selections window.
- **In Progress Only:** Appointments that have been checked in, are in progress and meet the date criteria set in the Appointment Search Selections window.
- **Needs Co-Signature:** Appointments that must have a provider's co-signature in order to be give a completed status and meet the date criteria set in the Appointment Search Selections window.
- **Updated:** Whenever an appointment is amended or appended, its status is changed to Updated. The updated appointments must meet the date criteria set in the Appointment Search Selections window.
- **Completed Only:** Appointments that have a completed status and meet the date criteria set in the Appointment Search Selections window.
- **Incomplete:** Appointments that are not complete and meet the date criteria set in the Appointment Search Selections window.

- **Checked In or Pending:** Appointments that are currently checked in or show a pending status in CHCS and that meet the date criteria set in the Appointment Search Selections window.

7.4 Creating a New Appointment

Within CHCS II, only new Unscheduled Visit (USV) appointments can be created. Scheduled appointments are still set up through CHCS and are then pulled into CHCS II, along with accompanying patient information.

Telephone Consults can also be created in the Appointments module. Once scheduled, though, they can only be seen in the Telephone Consults module.

Follow the steps below to create a new appointment:

1. Click **New Appt** on the Action bar.
2. The New Unscheduled Appointment/Telcon Visit window opens, immediately overlaid by the Patient Search window. If the patient for whom the appointment is being created is already loaded, click **Cancel** on the Patient Search window.

The screenshot shows a software interface for creating a new appointment. The main window is titled "New Unscheduled Appointment/Telcon Visit" and displays patient information for "ALEXANDER, VIOLET" with SSN "20/202-45-5743" and birth date "07 Jul 1957". It also shows "Home Phone: f1231333333" and "Work Phone: f1231333444". A "Change Patient ..." button is in the top right. Overlaid on this is a "Patient Search" window. This sub-window has a "Date" field set to "30 Sep". It contains several input fields: "Quick Search:", "Last Name:", "First Name:", "DOB:", "UIC:", "SSN:", "FMP:", "Sponsor SSN:", and "Sex:". There are buttons for "Find", "New Search", "New Patient", "Edit Patient", "Search CHCS", and "Next >>". A checkbox "Find only patients enrolled in this facility." is checked. On the left side of the Patient Search window, there is a vertical list of appointment types: "ACU", "EST", "GRO", "INITI", "PRO", "PRO", "ROU", "INITI", and "TELE". At the bottom of the Patient Search window are "OK" and "Cancel" buttons. The main window also has "OK" and "Cancel" buttons at the bottom.

Figure 7-4: Patient Search Window

3. If the patient's record is not loaded, search for the patient for whom you are scheduling the new appointment. After the patient record is loaded, the New Unscheduled Appointment/Telcon Visit window is fully displayed.

Figure 7-5: New Unscheduled Appointment Window

4. In the New Unscheduled Appointment window, complete the following fields:
 - **Date and Time:** The default is the current date and time and cannot be changed.
 - **Assigned Clinic:** Select the clinic from the drop-down list.

Note: Clinical Team Members are only able to create appointments for providers assigned to the clinics to which they have access.

- **Provider:** Use the drop-down list to select the desired provider. The provider must be associated with the selected clinic.

- **Appointment Type:** Select an appointment type from the pick list. Available options are based on the CHCS appointment types that are available for the clinic and provider selected.

Note: Appointment types with a \$ or * annotate those types of appointments that can only be created by the clinic.

- **USV Type:** Select Sick Call, as appropriate. The default is Walk-In.
- **Appointment Classification:** This is based on the appointment classification from CHCS and cannot be changed in CHCS II.
- **Observation:** Select **Observation**, if appropriate. A checkmark here affects the selection of E&M codes in the Disposition module.
- **Meets Outpt Visit Criteria (Workload)?:** This field determines whether this encounter is a count or no-count visit. Yes, is count; No is no-count. If No is selected, the available E&M codes are no-count codes.
- **Related to Inpatient Stay?:** If the selected patient has an appointment classification of inpatient, use this field to document the relationship between the reason the patient is admitted and the reason for the outpatient appointment. If this visit is related to the inpatient stay, the outpatient encounter is a no count. If the visit is not related to the inpatient stay, the encounter is counted as a regular outpatient visit.

Note: If the visit is not related to the inpatient stay, a confirmation window appears. Click **No** if the visit is not related.

- **Related to Injury/Accident?:** If the appointment is related to an injury or an accident, select this checkbox. The Date and Related Cause Code window appears.

Tip:
For CHCS scheduled appointments, this information can be captured in the A/P and Disposition modules.

Figure 7-6: Date and Related Cause Code Window

- Complete all fields and click **OK**. Notice the checkbox indicating that the date and Related Cause Code have been entered.

Note: An encounter marked as related to an injury or accident is required to contain an E-code as one of the diagnoses. A notification appears when you attempt to close the A/P module or sign the encounter if the encounter is marked as related to an injury or accident and no E-code (diagnosis) was selected.

- **Reason for Appointment:** Enter the reason the patient needs to be seen. This is a free text field.
 - **Comments:** Enter any additional information, if needed.
-

Note: The Reason for Appointment and Comments are displayed on the electronic SF600 once the encounter is opened.

- **Call Back Number:** This field is enabled when creating a telephone consult and defaults to the patient's home phone number. Change the number, as appropriate.
 - **Urgency:** This field is enabled when a telephone consult is selected. Low is the default setting. Select the radio button next to High or Medium, as appropriate.
5. Click **OK**. The appointment is displayed on the appointment list and the status is checked-in.
-

Tip:

Double-click on an appointment to begin documentation and open the encounter, if role allows.

Note: If you want to change the patient for whom you are creating the new appointment, click **Change Patient**. The Patient Search window opens, allowing you to search for the desired patient.

7.4.1 Creating a Rounds Appointment

Rounds (RNDS) appointments can be created and completed in CHCS II. RNDS appointments are scheduled on a daily basis by CHCS and are pulled into CHCS II just like any other type of appointment. RNDS appointments can also be created in CHCS II, by providers only, for patients with an appointment classification of inpatient. The workflow for RNDS appointments in CHCS II is the same for that of outpatient appointments. RNDS appointments are no-count for workload purposes and are associated with the current "A" level Medical Expense Performance Reporting System (MEPRS) code.

Follow the steps below to create a RNDS appointment:

1. On the New Unscheduled Visit window, in the Clinic field, click the drop-down arrow and select the Industry Based Workload Alignment (IBWA) clinic. Notice that the RNDS appointment type becomes available and is selected.

2. In the provider field, the default is the logged in provider. To select a different provider, click **IBWA Provider Search** to search for and locate another provider. The provider must be associated with the selected clinic.
3. Click **OK**. The Inpatient Admissions window displays.

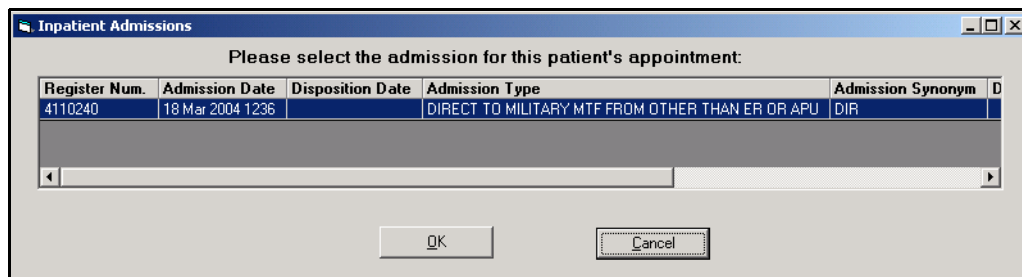


Figure 7-7: Inpatient Admissions Window

4. Select the admission for the patient.

Note: RNDS appointments require one of several admission types:

- ABS-AD DIRECT TO NON US MILITARY HOSPITAL NEVER TRNF TO MIL MTF
- RON-REMAIN OVERNIGHT
- CRO-CARDED FOR RECORD ONLY
- Absence Status

5. Click **OK**. The appointment is displayed on the appointment list and the status is checked-in.

7.5 Checking In a Patient

In the Appointments module, individual appointments that were scheduled in CHCS can be checked-in for their appointments. Appointments that are checked in from CHCS II do not need to be checked in on CHCS. Once an appointment is checked in, CHCS II updates the appointment status in CHCS to Kept. Patients arriving for a walk-in or sick call appointment are automatically checked-in upon creating the appointment in CHCS II.

Follow the steps below to check in a patient:

1. Select the appointment from the appointment list.

Note: You can only check in appointments whose status is Pending.

Tip:

To check-in multiple appointments, select an appointment from the appointments list and press Ctrl on your keyboard while selecting each additional appointments. Click Check-In on the Action bar.

2. On the Action bar, click **Check-In**.

Note: Appointments should not be modified in the End of Day processing in CHCS. CHCS II writes back the appointment statuses of appointments managed in CHCS II. Modifications in the EOD should not be necessary.

7.6 Checking Out a Patient

The Appointment Check Out window enables a patient to be checked out from the selected appointment. This does not change the status of the appointment, nor is this step required. On this window, forms can be selected to print for the patient.

The check out function allows the user to print out a patient copy of the SF 600, DD 2766 or a clinic-specific patient information form. Any orders entered for the patient are automatically printed to this form along with any wellness items that are due.

Follow the steps below to check out a patient:

1. Select an appointment with a status of In Progress, Complete, or Updated from the appointments list.
2. On the Action bar, click **Check-Out**. The Check Out window opens.

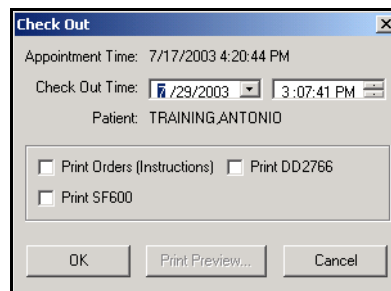


Figure 7–8: Check Out Window

3. Select the checkbox next to the associated print format.
4. Click **OK**. The forms are sent to your designated printer.

7.7 Adding an Additional Provider

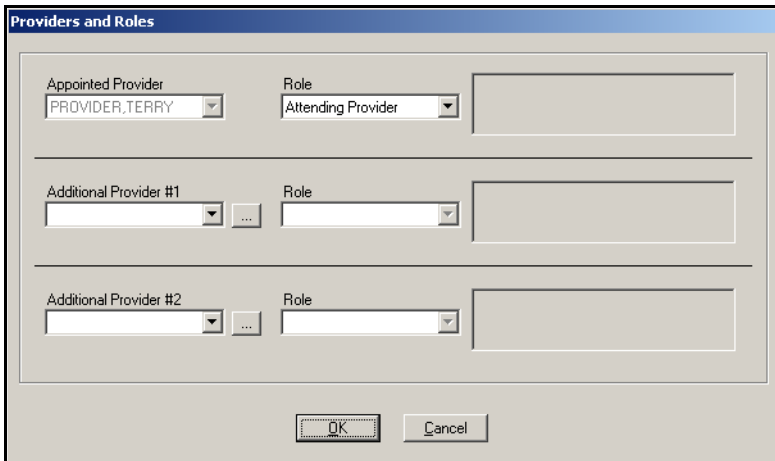
An additional provider can be added to an encounter to receive credit for work performed on a patient.

Follow the steps below to add an additional provider:

1. On the Action bar, click **Add Providers**. The Provider and Roles window is displayed.

Tip:

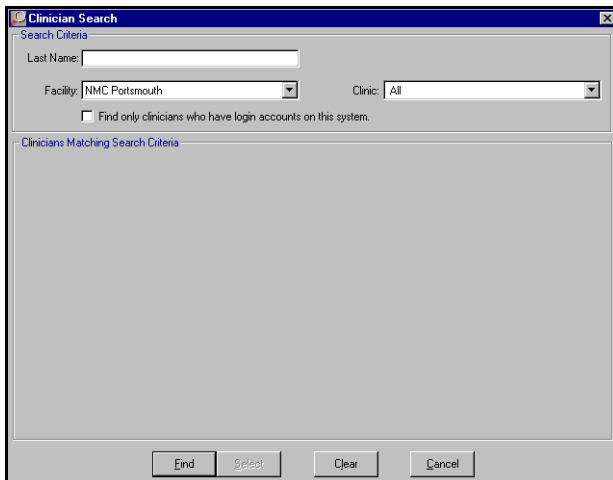
You can select more than one form. Click **Print Preview** to view the forms before printing.



The 'Providers and Roles' window contains three sections for adding providers. The first section, 'Appointed Provider', has a dropdown menu showing 'PROVIDER, TERRY' and a 'Role' dropdown menu showing 'Attending Provider'. The second section, 'Additional Provider #1', has an empty dropdown menu, an ellipsis button, and a 'Role' dropdown menu. The third section, 'Additional Provider #2', also has an empty dropdown menu, an ellipsis button, and a 'Role' dropdown menu. At the bottom are 'OK' and 'Cancel' buttons.

Figure 7-9: Providers and Roles Window

2. Select the type of clinician you want to add.
3. In the Additional Provider #1 area, click the **ellipsis** button to search for a provider. The Clinician Search window opens.



The 'Clinician Search' window has a 'Search Criteria' section with a 'Last Name' text field, a 'Facility' dropdown menu (showing 'NMC Portsmouth'), and a 'Clinic' dropdown menu (showing 'All'). There is a checkbox labeled 'Find only clinicians who have login accounts on this system.' Below this is a large empty area labeled 'Clinicians Matching Search Criteria'. At the bottom are 'End', 'Select', 'Clear', and 'Cancel' buttons.

Figure 7-10: Clinician Search Window

4. In the **Last Name** field, enter the last name of the desired clinician.
5. Select a facility from the drop-down list.
6. Select a clinic from the drop-down list.
7. Click the **Find only clinicians who have login accounts on this system** to view only providers associated with CHCS II.
8. Click **Find**. The results are displayed in the bottom half of the Clinician Search window.
9. Select the desired clinician.
10. Click **Select**. The name populates in the **Additional Provider** field on the Provider and Roles window.

11. Click the Role drop-down list to select the additional provider's role.

Note: Repeat steps 2-11 if you want to add a second additional clinician.

12. Click **OK**. The clinician(s) is(are) added to the appointment.

Tip:

To select multiple appointments, use the Ctrl key on your keyboard. If transferring multiple appointments, the patients must be from the same clinic.

7.8 Transferring an Appointment

The Appointment Transfer window enables an individual appointment or a group of appointments to be transferred to a different provider within the same clinic. Appointments can only be transferred to clinical team members who have the privilege to sign an encounter.

Follow the steps below to transfer an appointment:

1. Select the appointment(s) to be transferred from the appointments list.
2. On the Action bar, click **Transfer**. The Appointment Transfer window opens.

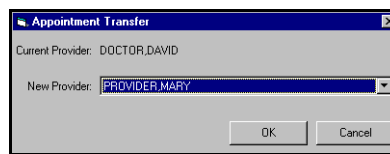


Figure 7-11: Appointment Transfer Window

3. Select the new provider from the drop-down list. Only providers assigned to the specific clinic are available.
4. Click **OK**. The appointment is assigned to the new provider.

7.9 Canceling an Appointment

The Cancel Appointment dialog box enables an appointment to be canceled. A reason for cancellation — Patient Cancelled, Facility Canceled, No Show, Left Without Being Seen — must be selected. Once an appointment is canceled, the appointment status is updated on the appointment list. If an appointment is inadvertently canceled, the user can undo the cancellation using the Undo button on the Action Bar. This action cannot be performed on appointments that were cancelled in the past.

Follow the steps below to cancel an appointment:

1. Select the appointment to be canceled from the appointment list.
2. On the Action bar, click **Cancel**. The Cancel Appointment window opens.

Tip:

To select multiple appointments, use the Ctrl key on your keyboard.

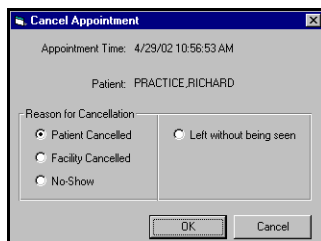


Figure 7–12: Cancel Appointment Window

3. Select a Reason for Cancellation.

Note: Once a patient has been checked in, the only cancel options available are Left Without Being Seen (LWOBS) or Facility Cancelled.

4. Click **OK**. This completes the encounter and the canceled appointment appears in the Previous Encounter module indicating that the appointment was cancelled.

Note: If the appointment was canceled by mistake, select the appointment and click **Undo Cancel** on the Action bar.

7.10 Printing the Insurance Form

A copy of the patient's insurance information can be printed for verification or to note changes. The form can also be printed from the Appointments and Demographics modules. This form defaults to the current date and includes demographic information with space to update the address, phone numbers, current insurance information, and questions for the patient to answer regarding any changes.

Follow the steps below to print the Insurance Form:

1. Click **Ins. Form** on the Action bar to print an insurance form for a patient. The Print Preview window opens.
2. Click the printer icon on the Preview window to print the form. The form is sent to your designated printer.

7.11 Viewing a Comment Associated with an Appointment

If a comment was added on the New Appointment window, the full text of the comment can be viewed and edited. New comments can be added as well.

Follow the steps below to view a comment associated with an appointment:

1. Select the appointment that contains the comment.
2. On the Action bar, click **View Comments**. The Appointment Comments window opens.

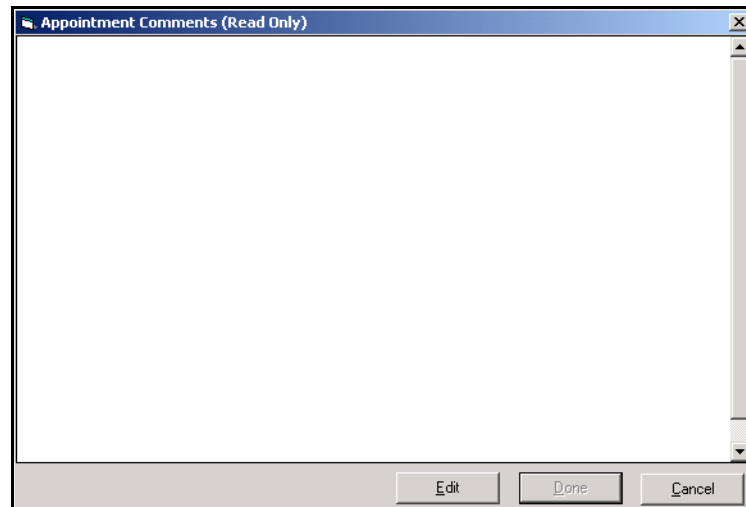


Figure 7-13: Appointment Comments Window

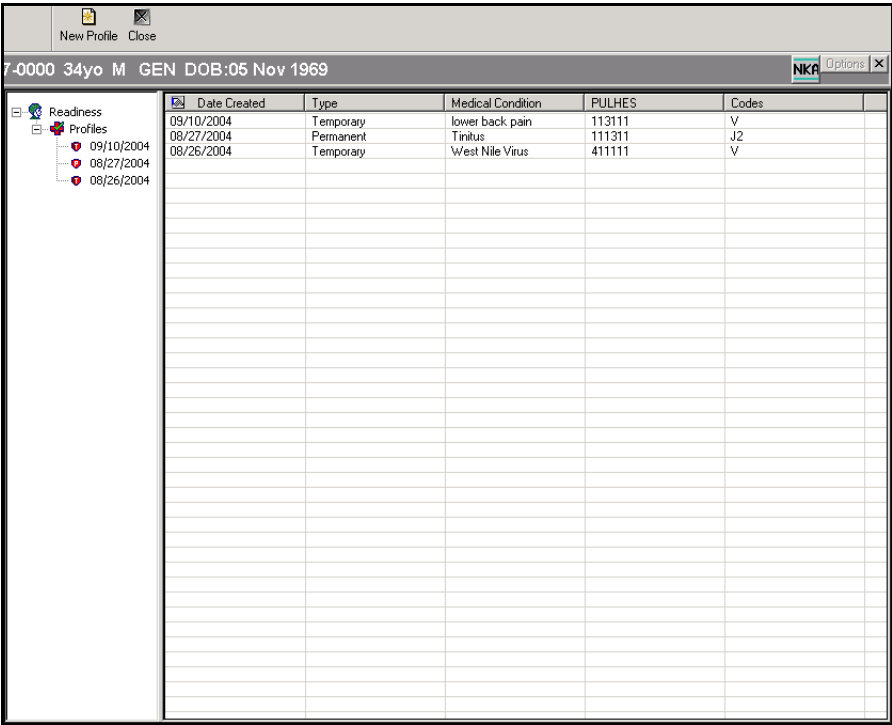
3. To edit the comments, click **Edit**. The Appointment Comments window changes from (Read Only) to (Edit Mode). Make the applicable changes.
4. Click **Done**.

8.0 ARMY PROFILE

8.1 Army Profile Overview

For users assigned appropriate roles, Army Profile enables you to create and track Army profiles for a patient. The profile form (DA FORM 3349) is implemented by surfacing the current Medbase profile functionality. As with the current Medbase product, a new profile can be filled out (with subsequent edits allowed) by using a blank profile or a profile template. Once a profile is complete, you can save it to the Army Readiness module, save the profile as a template and print the DA FORM 3349 for required signatures on the hard copy and insertion in the patient’s medical record.

Note: Authorization to use this functionality is currently limited to Fort Bliss. Its use by additional Army sites may be approved, in the future, by the Office of the Surgeon General (OTSG).



The screenshot displays a software window titled "7-0000 34yo M GEN DOB:05 Nov 1969" with a "New Profile" button and a "Close" button. On the left, a tree view shows "Readiness" and "Profiles" with a list of dates: 09/10/2004, 08/27/2004, 08/26/2004, and 08/26/2004. The main area contains a table with the following data:

Date Created	Type	Medical Condition	PULHES	Codes
09/10/2004	Temporary	lower back pain	113111	V
08/27/2004	Permanent	Tinnitus	111311	J2
08/26/2004	Temporary	West Nile Virus	411111	V

Figure 8-1: Military Clinical Desktop—Army Readiness Module

8.1.1 In More Depth

In the current release, this functionality is completely separate and distinct from the Temporary Profile capability that becomes available in the Disposition module when the patient’s disposition is “Released w/work/duty/limitations.” Accordingly, if creat-

ing a Temporary Profile for a patient that is related to an encounter, the profile needs to be documented in the Disposition module so that it becomes a part of the encounter. Additionally, the Army Profile templates that are created and used in the Army Readiness module are unrelated to other CHCS II template capabilities.

8.1.2 Creating a New Profile

Follow the steps below to create a new profile:

1. Click **New Profile** on the Action bar. The Create a New Physical Profile window opens.

Note: The window contains two generic System Templates.

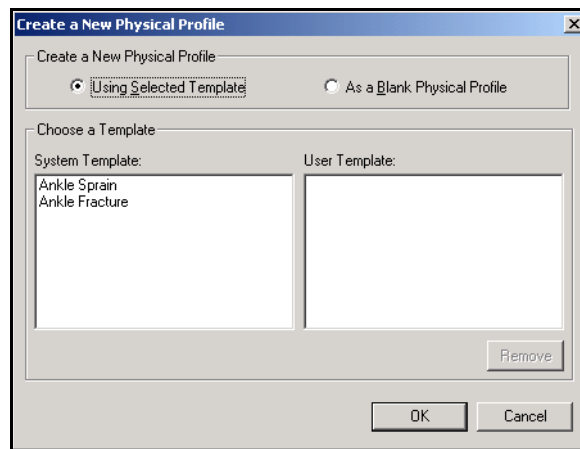


Figure 8–2: Create a New Physical Profile Window

2. Select the **As a Blank Physical Profile** radio button and click **OK**. A blank Physical Profile form appears on top of the module.

Profile Date: 08/25/2004

New Physical Profile

1. MEDICAL CONDITION (Description in lay terminology)
☐ INJURY? ☐ ILLNESS/DISEASE?

2. CODES (Table 7-2 AR 40-501)

3. P U L H E S
 Temporary ☐ ☐ ☐ ☐ ☐ ☐
 Permanent ☐ ☐ ☐ ☐ ☐ ☐

4. PROFILE TYPE
 a. Temporary Profile (Expiration Date: 8/25/2004 (Limited to 3 months duration) ☐ YES ☐ NO
 b. Permanent Profile (Reviewed and Validated with every periodic physical exam or after 5 years from the date of issue) ☐ YES ☐ NO
 c. If a permanent profile with a 3 or 4 PULHES, does the soldier meet retention standard IAW Chapter 3 AR 40-501? ☐ Needs MMRB ☐ Needs MED/PEB

5. FUNCTIONAL ACTIVITIES FOR PERMANENT AND TEMPORARY PROFILES
 (If any answer (a-f) is NO then the profile should be at least a 3)
 a. able to carry and fire Individual Assigned Weapon ☐ YES ☐ NO
 b. able to move with a fighting load at least 2 miles (48 Lbs. includes helmet, boots, uniform, LBE, weapon, protective mask, pack, etc.) ☐ YES ☐ NO
 c. able to wear protective mask and all chemical defense equipment ☐ YES ☐ NO
 d. able to construct an individual fighting position (dig, fill, lift sand bags, etc.) ☐ YES ☐ NO
 e. able to do 3-5 second rushes under direct and indirect fire ☐ YES ☐ NO
 f. is soldier healthy without any medical condition that prevents deployment? ☐ YES ☐ NO

6. APFT
 2 Mile Run ☐ YES ☐ NO
 APFT Sit-Ups ☐ YES ☐ NO
 APFT Push-Ups ☐ YES ☐ NO
 ALTERNATE APFT (Fill out if unable to do APFT run otherwise N/A)
 APFT Walk ☐ YES ☐ NO
 APFT Swim ☐ YES ☐ NO
 APFT Bike ☐ YES ☐ NO

7. STANDARD OR MODIFIED AEROBIC CONDITIONING ACTIVITIES (Check all applicable boxes)
 Unlimited Running ☐ YES ☐ NO
 Unlimited Walking ☐ YES ☐ NO
 Unlimited Biking ☐ YES ☐ NO
 Unlimited Swimming ☐ YES ☐ NO
 Or Run at Own Pace and Distance ☐ YES ☐ NO
 Or Walk at Own Pace and Distance ☐ YES ☐ NO
 Or Bike at Own Pace and Distance ☐ YES ☐ NO
 Or Swim at Own Pace and Distance ☐ YES ☐ NO

Figure 8-3: Blank Physical Profile Form

Note: The field numbers on the form do not correspond exactly to the numbers on the DA Form 3349. For example, Blocks 13, 17 and 22 are blank fields for signatures on the DA Form 3349 and do not appear on the profile form.

3. Complete blocks 1–5 of the form as follows:

- **Block 1:** Check either **Injury**, **Illness/Disease**, or both, if applicable, and enter the description.
- **Block 2:** Enter the appropriate Code(s).

Note: For a complete list of codes refer to Table 7-2 of Army Regulation (AR) 40-501.

- **Block 3:** Enter a single number from 1-4 in each of the boxes under the **P** (Physical Capacity), **U** (Upper Extremities), **L** (Lower Extremities), **H** (Hearing), **E** (Eyes), and **S** (pSychiatric) columns. If the Profile is to be Permanent, enter the numbers in the **Permanent** row.

Note: For a complete description of the numerical values used in the boxes, refer to Table 7-1 of AR 40-501.

- **Block 4:** For a Temporary Profile, select the **Expiration Date** from the pop-up calendar and select the **YES** radio button. When you do this, all remaining options related to Permanent Profiles become disabled. For a Permanent Profile, complete “b” and “c” as appropriate.

- **Block 5:** Select the appropriate **YES** or **NO** radio buttons for items a–f.
4. Complete blocks 6–11 as appropriate.
 5. Complete blocks 12–26 of the form as follows:
 - Click **Profiling Officer** in Block 12. The Signature of Profiling Officer window displays. Enter the Profiling Officer's **Name** and **Grade** and click **OK**.

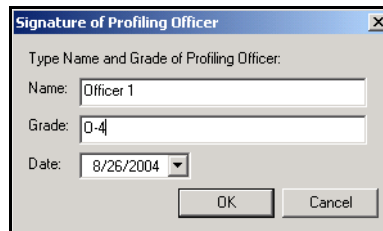

 A screenshot of the 'Signature of Profiling Officer' dialog box. It has a title bar with a close button. The main area contains the text 'Type Name and Grade of Profiling Officer:'. Below this are three input fields: 'Name:' with the text 'Officer 1', 'Grade:' with the text 'O-4', and 'Date:' with a dropdown menu showing '8/26/2004'. At the bottom right are 'OK' and 'Cancel' buttons.

Figure 8–4: Signature of Profiling Officer Window

- Complete the same actions for the **Approving Officer** (Block 16) and **Unit Commander** (Block 19) blocks.
 - Select the appropriate radio buttons in Blocks 15 and 19.
6. Complete the **Medical Facility** field (Block 24). Enter the facility in the free text field or search for a MEPRS identifier by clicking **MEDICAL FACILITY**. The MEPRS Search window opens.

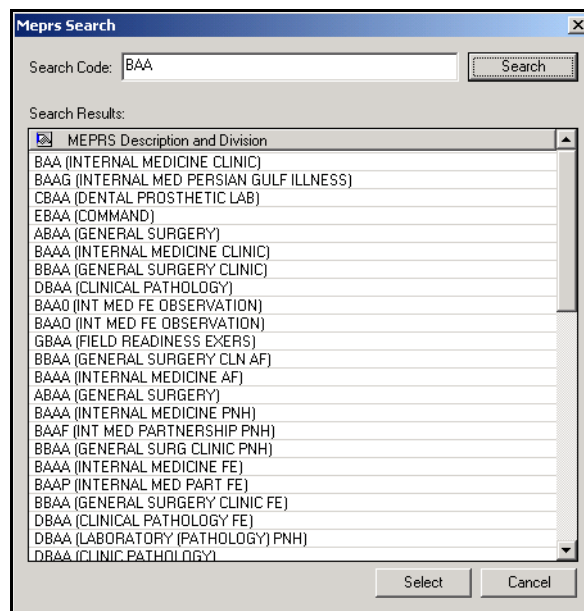

 A screenshot of the 'MEPRS Search' dialog box. It has a title bar with a close button. At the top is a 'Search Code:' text box containing 'BAA' and a 'Search' button. Below is a 'Search Results:' section with a list box containing a long list of MEPRS codes and descriptions, such as 'BAA (INTERNAL MEDICINE CLINIC)', 'BAA (INTERNAL MED PERSIAN GULF ILLNESS)', 'CBAA (DENTAL PROSTHETIC LAB)', 'EBAA (COMMAND)', 'ABAA (GENERAL SURGERY)', 'BAAA (INTERNAL MEDICINE CLINIC)', 'BBAA (GENERAL SURGERY CLINIC)', 'DBAA (CLINICAL PATHOLOGY)', 'BAAO (INT MED FE OBSERVATION)', 'BAAO (INT MED FE OBSERVATION)', 'GBAA (FIELD READINESS EXERS)', 'BBAA (GENERAL SURGERY CLN AF)', 'BAAA (INTERNAL MEDICINE AF)', 'ABAA (GENERAL SURGERY)', 'BAAA (INTERNAL MEDICINE PNH)', 'BAAF (INT MED PARTNERSHIP PNH)', 'BBAA (GENERAL SURG CLINIC PNH)', 'BAAA (INTERNAL MEDICINE FE)', 'BAAO (INTERNAL MED PART FE)', 'BBAA (GENERAL SURGERY CLINIC FE)', 'DBAA (CLINICAL PATHOLOGY FE)', 'DBAA (LABORATORY (PATHOLOGY) PNH)', and 'DBAA (CLINIC PATHOLOGY)'. At the bottom right are 'Select' and 'Cancel' buttons.

Figure 8–5: MEPRS Search Window

- Search for and select the desired MEPRS code and click **Select**. Block 24 populates with your selection.
7. Complete the **Unit** field (Block 25). Click **UNIT** to search for the patient's unit. The Unit Search window opens.

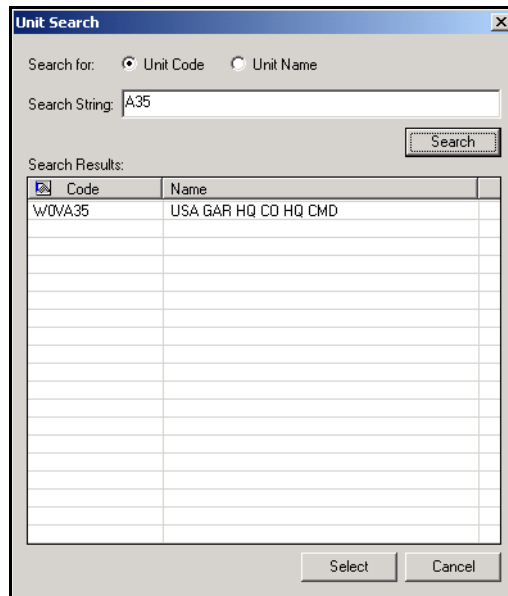


Figure 8–6: Unit Search Window

- Search for the desired **Unit Code** or **Unit Name**. Highlight the appropriate item and click **Select**. Block 25 populates with your selection.
8. Complete the free text fields in Block 26, if desired.
 9. Click **Save** on the Action bar. The profile is saved to the Army Readiness module. Click **Cancel** to clear the Profile Form from the workspace.

[illegible]

Figure 8–7: Army Readiness Module—Temporary Profile

Note: The letter “T” in the icon preceding the date in the Profile Tree identifies the profile as a Temporary Profile. The letter “P” identifies it as a Permanent Profile.

8.2 Creating a Profile Template

Follow the steps below to save a completed or partially completed Profile Form as a template:

1. Select the profile.
2. Click **Save as Template** on the Action bar. The New Physical Profile Template window opens.

New Physical Profile Template

Create a New Physical Profile Template

☒ As a User Template ☐ As a System Template

Describe Template

Name:

Medical Condition:

OK Cancel

Figure 8–8: New Physical Profile Template Window

3. Select the type of template desired. Select the **As a System Template** radio button to save the template as an Enterprise template. Enterprise templates cannot be deleted.
4. The Template type defaults to **As a User Template** and the Name defaults to the medical condition you entered on the Profile form in Block 1. You can also change the Name of the template if you desire.
5. Click **OK**. The template is saved and is immediately available to you for use with another patient.

8.3 Using an Army Profile Template

Follow the steps below to use an Army Profile template:

1. Click **New Profile** on the Action bar. The Create a New Physical Profile window opens.

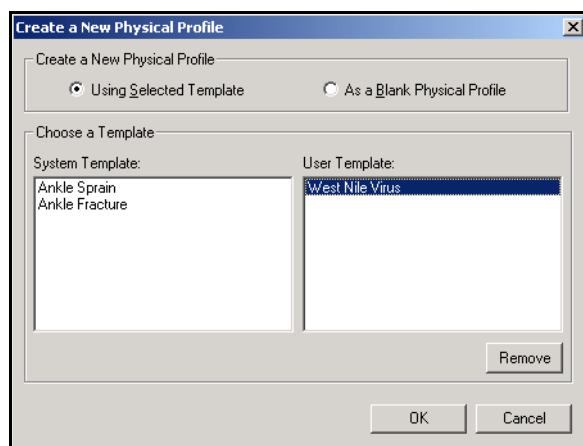


Figure 8–9: Create a New Physical Profile Window

2. Select either a **System Template** or a **User Template** and click **OK**. The template Profile Form displays.

Note: The system contains several generic system templates. These include the following:

- Ankle Sprain
 - Ankle Fracture
-

Readiness
 Profiles

Profile Date: 08/26/2004
 New Physical Profile

1. MEDICAL CONDITION (Description in lay terminology) <input type="checkbox"/> INJURY? <input checked="" type="checkbox"/> ILLNESS/DISEASE? <div>West Nile Virus</div>		2. CODES (Table 7-2 AR 40-501) <div>V</div>		3. Temporary <input type="checkbox"/> P <input type="checkbox"/> U <input type="checkbox"/> L <input type="checkbox"/> H <input type="checkbox"/> E <input type="checkbox"/> S <input type="checkbox"/> Permanent <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
--	--	---	--	--	--

4. PROFILE TYPE

a. Temporary Profile (Expiration Date: 11/26/2004 (Limited to 3 months duration)) ☒ YES ☐ NO

b. Permanent Profile (Reviewed and Validated with every periodic physical exam or after 5 years from the date of issue) ☐ YES ☒ NO

c. If a permanent profile with a 3 or 4 PULHES, does the soldier meet retention standard IAW Chapter 3 AR 40-501? ☐ Needs MMRB ☒ Needs MED/PEB

5. FUNCTIONAL ACTIVITIES FOR PERMANENT AND TEMPORARY PROFILES
 (If any answer (a-f) is NO then the profile should be at least a 3)

a. able to carry and fire Individual Assigned Weapon ☐ YES ☒ NO

b. able to move with a fighting load at least 2 miles (48 Lbs. includes helmet, boots, uniform, LBE, weapon, protective mask, pack, etc.) ☐ YES ☒ NO

c. able to wear protective mask and all chemical defense equipment ☐ YES ☒ NO

d. able to construct an individual fighting position (dig, fill, lift sand bags, etc.) ☐ YES ☒ NO

e. able to do 3-5 second rushes under direct and indirect fire ☐ YES ☒ NO

f. is soldier healthy without any medical condition that prevents deployment? ☐ YES ☒ NO

6. APFT 2 Mile Run <input type="radio"/> YES <input checked="" type="radio"/> NO APFT Sit-Ups <input type="radio"/> YES <input checked="" type="radio"/> NO APFT Push Ups <input type="radio"/> YES <input checked="" type="radio"/> NO		ALTERNATE APFT (Fill out if unable to do APFT run otherwise N/A) APFT Walk <input type="radio"/> YES <input checked="" type="radio"/> NO APFT Swim <input type="radio"/> YES <input checked="" type="radio"/> NO APFT Bike <input type="radio"/> YES <input checked="" type="radio"/> NO	
--	--	---	--

7. STANDARD OR MODIFIED AEROBIC CONDITIONING ACTIVITIES (Check all applicable boxes)

Unlimited Running ☐ YES ☒ NO
 Unlimited Walking ☐ YES ☒ NO
 Unlimited Biking ☐ YES ☒ NO

Or Run at Own Pace and Distance ☐ YES ☒ NO
 Or Walk at Own Pace and Distance ☐ YES ☒ NO
 Or Bike at Own Pace and Distance ☐ YES ☒ NO

Figure 8–10: User Template Loaded

3. Make any changes necessary to the Profile Form and click **Save**. The Physical Profile, with the changes you have made, is saved to the Army Readiness module. Click **Cancel** to close the Profile Form. The new profile is displayed in the Army Readiness module.

[illegible]

Figure 8–11: Army Readiness Module—Temporary Profile

8.4 Viewing and Printing the DA Form 3349

Follow the steps below to view and print the DA 3349:

1. Right-click the profile in the Profile Tree, and select **Preview Profile Report** from the pop-up menu. The DA Form 3349 displays.

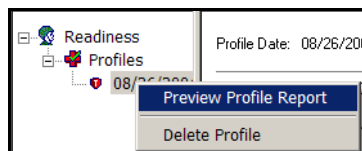


Figure 8-12: Right-Click Menu—Preview Profile Form Selected

 A screenshot of the DA Form 3349 Physical Profile form. The form is titled 'PHYSICAL PROFILE' and includes instructions for use. It contains several sections:

- 1. MEDICAL CONDITION:** (Description in lay terminology) ☐ INJURY? Or ☒ ILLNESS/DISEASE?
 - 2. CODES (Table 7-2 AR 40-501): J2
 - 3. Temporary / Permanent: Temporary
- 4. PROFILE TYPE:**
 - a. TEMPORARY PROFILE (Expiration date: YYYYMMDD) (Limited to 3 months duration)
 - b. PERMANENT PROFILE (Reviewed and validated as a minimum with every periodic physical exam greater 6 years from the date of issue)
- 5. FUNCTIONAL ACTIVITIES FOR PERMANENT AND TEMPORARY PROFILES:** (If any answer (a-f) is NO then the profile should be at least a 2)
 - a. ABLE TO CARRY AND FIRE INDIVIDUAL ASSIGNED WEAPON
 - b. ABLE TO MOVE WITH A FIGHTING LOAD AT LEAST 2 MILES (45 LBS. Includes helmet, boots, uniform, LBE, weapon, protective mask, pack, etc.)
 - c. ABLE TO WEAR PROTECTIVE MASK AND ALL CHEMICAL DEFENSE EQUIPMENT
 - d. ABLE TO CONSTRUCT AN INDIVIDUAL FIGHTING POSITION (dig, fill & lift sand bags, etc.)
 - e. ABLE TO DO 3-5 SECOND RUSHES UNDER DIRECT AND INDIRECT FIRE
 - f. IS SOLDIER HEALTHY WITHOUT ANY MEDICAL CONDITION THAT PREVENTS DEPLOYMENT?
- 6. APFT:**

	YES	NO	ALTERNATE APFT (Fill out if unable to do APFT run otherwise)
2 MILE RUN			APFT WALK
APFT SIT-UPS			APFT SWIM
APFT PUSH UPS			APFT BIKE
- 7. STANDARD OR MODIFIED AEROBIC CONDITIONING ACTIVITIES:** (Check all applicable boxes)

UNLIMITED RUNNING			OR RUN AT OWN PACE & DISTANCE
UNLIMITED WALKING			OR WALK AT OWN PACE & DISTANCE
UNLIMITED BIKING			OR BIKE AT OWN PACE & DISTANCE
UNLIMITED SWIMMING			OR SWIM AT OWN PACE & DISTANCE
- 8. UPPER BODY WEIGHT TRAINING:** (See FM 21-20)
- 9. LOWER BODY WEIGHT TRAINING:** (See FM 21-20)

Figure 8-13: DA Form 3349

2. Click the **printer** icon on the Print Preview window. The DA Form 3349 prints and the hardcopy can then be signed and inserted in the patient's medical record.

Note: If you do not want to view a print preview, click **Print** on the Action bar.

8.5 Deleting a Profile

Follow the steps below to delete a profile:

1. Right-click the profile in the Profile Tree and select **Delete Profile** from the pop-up menu. A warning window displays.

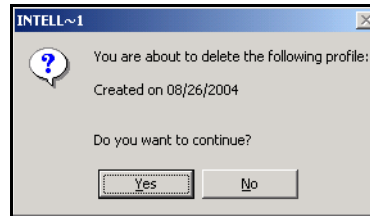


Figure 8–14: Delete Warning Window

2. On the warning window, click **Yes**. The profile is removed from the Army Readiness module.

8.6 Removing a User Profile Template

Follow the steps below to remove a user profile template:

1. Click **New Profile** on the Action bar. The Create a New Physical Profile window opens.

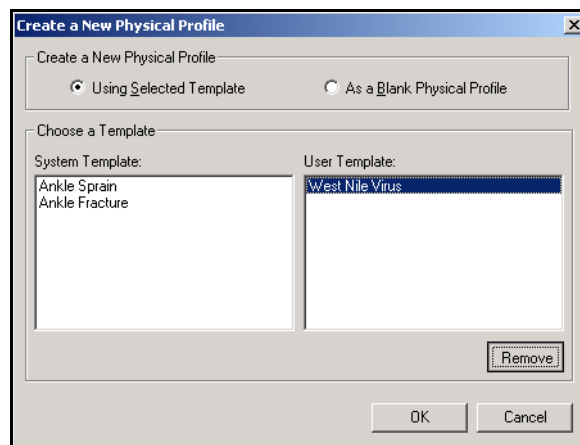


Figure 8–15: User Template Selected for Removal

2. Select the User Template you want to remove and click **Remove**. The Delete Profile Template Warning window displays.

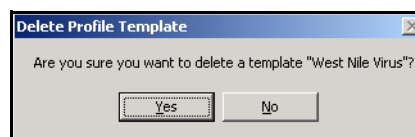


Figure 8–16: Delete Profile Template Warning Window

3. Click **Yes**. The User Template is removed.

Note: You cannot remove Enterprise (System) level templates.

9.0 ASSESSMENT AND PLAN (A/P)

9.1 Assessment and Plan Overview

The A/P module allows you to document your assessment of a patient's condition and the plan for treatment by entering diagnoses, procedures, patient instructions, and ordering consults, laboratory and radiology procedures, and medications.

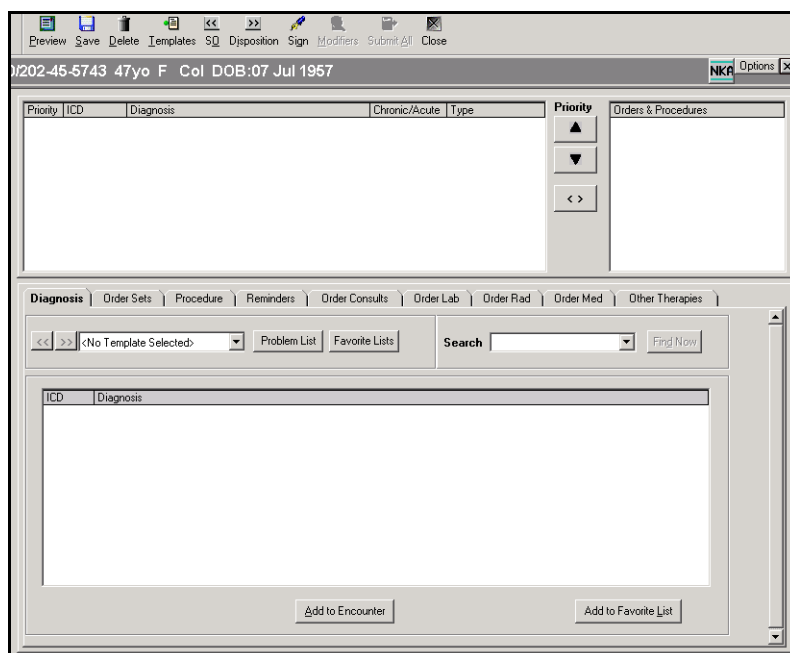


Figure 9-1: Military Clinical Desktop—Assessment and Plan Module

9.1.1 In More Depth

When the A/P module is opened, the Diagnosis tab is displayed by default. The rest of the tabs, along with the Diagnosis tab, are where you locate items to add to the Diagnosis box at the top of the module. This box displays the diagnoses for this patient and is the interface by which you associate procedures and order consults, medications, lab and radiology tests to one or more diagnoses. Provided buttons also enable the priority of a diagnosis to be changed and orders to be submitted from the queue. Each of these tasks are covered in this section.

9.2 Associating Procedures, Orders, and Instructions

You can enter procedures, orders, and consults (patient instructions) without associating a diagnosis. If you enter one without associating a diagnosis and attempt to close the A/P module, the system displays an alert.

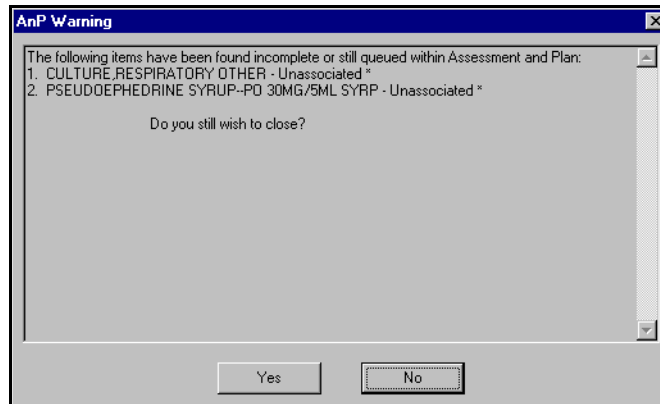


Figure 9-2: AnP Warning Window

All orders without a diagnosis receive a Count/No Count message if you attempt to sign the encounter without associating a diagnosis to a procedure, order, or consult.

9.3 Documenting a Diagnosis

When displayed, a diagnosis entry includes the name of the diagnosis and its associated ICD code. This is one of the ways CHCS II merges documentation and coding. By simply adding the diagnosis, the corresponding ICD code is documented as well. E-Codes, for injuries or accidents, cannot be selected as a primary diagnosis. An information box displays if you attempt to select E-Code as a primary diagnosis.

The diagnoses are added in the order in which they are selected and priorities are also associated in the same order. The first four diagnoses are sent to Standard Ambulatory Data Record (SADR). This is similar to the “bubble sheet” process of selecting diagnoses in priority order of 1–4. The maximum number of diagnoses allowed in CHCS II is 15.

Follow the steps below to document a diagnosis:

1. On the A/P module, click **Diagnosis** to view the Diagnosis tab.

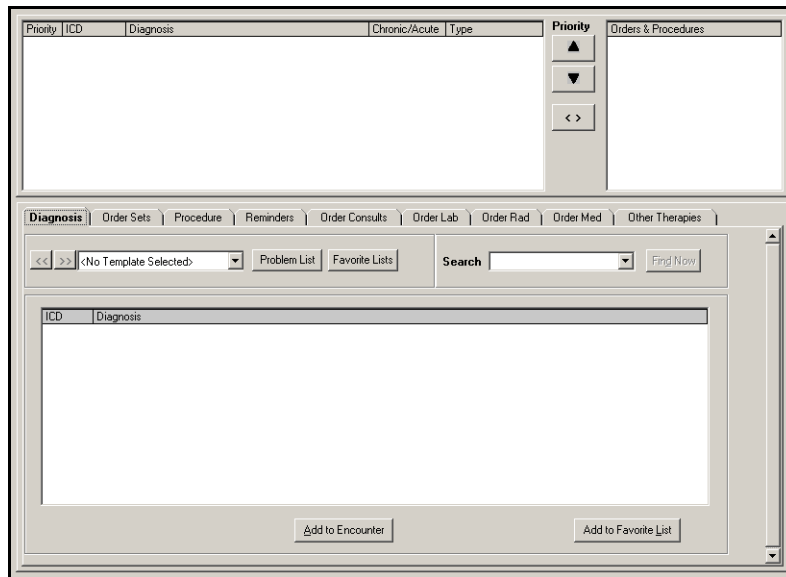


Figure 9-3: A/P Diagnosis Tab

2. Locate the diagnosis using one of the following methods:
 - **Template List:** If an encounter template is loaded, the list defaults to the diagnoses associated with the encounter template. Use the drop-down list to select an encounter template and view default diagnoses for the selected encounter template. Click the backward and forward buttons to view templates you have already loaded without using the drop-down list.
 - **Problem List:** Active Acute or Chronic diagnoses listed in the Problems module display if you click Problem List.
 - **Clinic List:** This list allows you to view diagnoses established by a clinic or user in the List Management module.
 - **Search:** In the Search field, enter the diagnosis and click **Find Now**. At least 2 characters must be entered. An alert message displays if the search criteria returns more than 150 results.
3. In the list of diagnoses, select the diagnosis you want to add to the encounter. The diagnosis must have an associated ICD code to be added.
4. Click **Add to Encounter**. The diagnosis is added to the list above in the Diagnosis box.

Note: Click **Add to Favorite List** if you want to add the selected diagnosis to your Favorites List. The diagnosis also displays in the List Management module.

- Highlight the diagnosis to be changed and click on either the ▲ or ▼ button to move the item up or down to change the priority of the diagnosis.
-

Priority	ICD	Diagnosis	Chronic/Acute	Type
1	465.9	UPPER RESPIRATORY INFECTION	Chronic	Follow-Up

Priority: ▲ ▼

Orders & Procedures

< >

Figure 9-4: Added Diagnosis

5. A comment may be entered for an added diagnosis.
 - a. Select a diagnosis that was added to the Diagnosis box. Be sure the diagnosis has been expanded to display the comment underneath.
 - b. Click **Comment**. The Extended Comments window opens.
 - c. In the Comments box, enter a comment.
 - d. Click **OK**.
6. When a diagnosis is added, it is labeled **Chronic** or **Acute**. Select the added diagnosis, and click the default label (Chronic or Acute) to change the default. A drop-down list displays allowing you to select **Chronic** or **Acute**.

Note: When you perform a diagnosis search using an ICD code, the result is based on a chart that lists those diagnoses that should be chronic and those that should be acute. Diagnoses selected from the patient's problem list default to Chronic.

7. When the diagnosis is added, the type is either **New** or **Follow-up**. Select the added diagnosis and click the default type (New or Follow-Up) to change the diagnosis type. A drop-down list displays allowing you to select **New** or **Follow-Up**. If a diagnosis is on the patient's problem list, it is automatically set to Follow-Up.

9.3.1 Documenting an E-code for Injury/Accident

If the appointment is related to an injury or an accident an E-code diagnosis must be documented to explain the related cause. Enter the clinical diagnosis as the primary diagnosis and the E-code as a secondary diagnosis. A notification appears when you attempt to close the A/P module or sign the encounter if the encounter is marked as related to an injury or accident and no E-code (diagnosis) was selected.

Follow the steps below to add an e-code:

1. Search for and locate the appropriate E-code. E-codes range from E800 - E999.
2. Select the diagnosis and click **Add to Encounter**. The Date and Related Cause Code window appears.

Figure 9–5: Date and Related Cause Code Window

- Complete all the fields and click **OK**. If this encounter has already been marked as related to an injury or accident, you simply need to verify the information in the Related Cause Code window.

9.4 Creating an Order Set from A/P

Building an order set is not an intuitive process and must be done inside an open encounter. The best method is to use the A/P module to locate and save orders as part of an order set. Although orders should not be submitted as part of this process, it is best to be safe and create an appointment for a test patient in the test clinic.

Follow the steps below to create an order set from A/P:

- In the A/P module, begin on one of the Order Entry tabs (Labs, Rads, or Meds).
- Locate the first order you want to include in the order set.
- When you have located the order, click **Save to Queue**. This saves the order without submitting it.
- Continue with all three tabs, as appropriate, locating individual orders and clicking Save to Queue.

Tip:
Once an order has been submitted, it cannot be included in an order set. Orders must be located and then Saved to Queue.

Note: For Med and Rad orders, the SIG and clinical impression is used as the default for those orders. These can be changed when using the order set in an actual encounter.

- Once you have finished locating the orders you want to include in your order set, click the **Order Set** tab to display the orders that have been saved to queue.

Select	Name	Details	Modify
<input checked="" type="checkbox"/>	CHEM 7	Routine BLOOD	<input type="checkbox"/>
<input checked="" type="checkbox"/>	CHEST, PA AND LATERAL	Routine	<input type="checkbox"/>

Figure 9–6: Order Sets Tab

6. Click **Save as Order Set**.
7. In the Save Encounter Template window **Template Name** field, enter the template name you want to use for the order set.
8. Click **Save** to save the order set. The order set encounter template can now be merged with other encounter templates and/or accessed in the Template Management and A/P modules.

9.4.1 Adding Orders to an Existing Encounter Template

An order set can also be saved as part of an encounter template that has already been built.

Follow the steps below to add orders to an existing template:

1. Locate your order(s) and save them to queue, following steps 1 - 4 above.
2. Once you have finished locating the order(s) you want to include in your order set, click the **Order Set** tab to display the orders that have been saved to queue.

Select	Name	Details	Modify
<input checked="" type="checkbox"/>	PREDNISONE (DELTA SONE) 1-P0 10MG TAB	11 TAB PO QID.#90 QTY 90 RF 0	<input type="checkbox"/>
<input type="checkbox"/>	CHEM 7	Routine BLOOD	<input type="checkbox"/>
<input type="checkbox"/>	CHEST, PA AND LATERAL	Routine	<input type="checkbox"/>

Figure 9–7: A/P Order Sets Tab

3. Click **Save as Order Set**.
4. In the Save Encounter Template window, select the encounter template to add to and click **Save**.

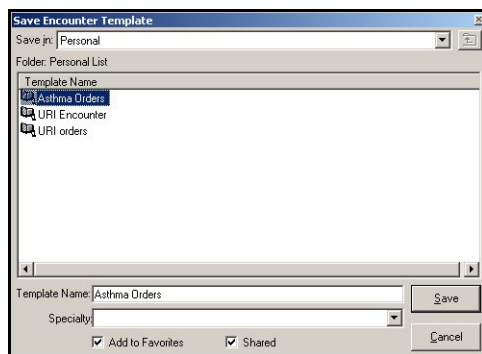


Figure 9-8: Save Encounter Template Window

5. A pop-up window opens asking if you want to Replace or Add To the existing template. Click **Add To**. The selected order(s) is(are) added to the existing template and can be viewed in the Template Management module or within A/P when the template is loaded.

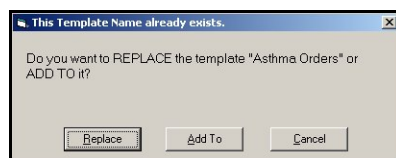


Figure 9-9: Template Name Option Box

9.5 Documenting a Procedure

The Procedure tab allows you to document and take credit for in-office procedures. Workload credit can be given to the clinical team member performing the procedure as well.

Just like the diagnoses, each procedure includes the associated CPT code. These codes are part of how CHCS II enables you to code as you document. Each procedure added here automatically adds the corresponding code to the E&M calculator in the Disposition module, ensuring accurate and complete coding for performed procedures.

Each procedure must be associated with a diagnosis and can be associated with multiple diagnoses. Associating each procedure with at least one diagnosis is a CMMS rule and is required for billing purposes. At the Enterprise-level, this association is a quality of care issue that enables the MHS to ensure that proper procedures are being performed for appropriate diagnoses.

Follow the steps below to document a procedure:

1. On the A/P module, click **Procedure** to view the Procedure tab.

Figure 9–10: A/P Procedure Tab

2. The procedure list can be viewed using the following methods:
 - **Template List:** If an encounter template is loaded, the list defaults to the procedures associated with the encounter template. Use the drop-down list to select an encounter template and view default procedures for the selected encounter template. Click the backward and forward buttons to view templates you have already loaded without using the drop-down list.
 - **Clinic List:** Click **Clinic List** to view a list of pre-selected procedures created at the clinic or user level.
 - **Search:** In the Search field, enter the procedure and click **Find Now**. At least 2 characters must be entered. If you want to search for standard procedures, select **Standard Procedures (CPTs)**. If you want to search for Health Care Financing Administration Common Procedure Coding System (HCPCS) and durable medical equipment, select **HCPCS and Durable Med Equip (DME)**.
3. In the list of procedures, select the procedure you want to add to the encounter.
4. In the Diagnosis box, select the diagnosis with which to associate the procedure.
5. Click **Add to Encounter**. The procedure is added to the Orders and Procedures area.

Note: Click **Add to Favorite List** if you want to add the selected procedure to your Favorites List. The procedure also displays in the List Management module.

Note: If you attempt to exit the A/P module and the procedure is not associated to a diagnosis, a warning message displays. Click **Yes** to save and close the mod-

ule without associating the procedure to the diagnosis or **No** to go back and associate the procedure with the diagnosis.

Priority	ICD	Diagnosis	Chronic/Acute	Type	Priority	Orders & Procedures
1	465.9	UPPER RESPIRATORY INFECTION	Chronic	Follow-Up		Pulmonary Function Tests Peak Flow

Figure 9-11: Added Procedures

9.6 Linking a Clinical Team Member to a Procedure

Provider Procedure Linking enables users to link additional clinical team members to a procedure. All information is sent to ADM easily recording correct workload credit.

1. On the A/P module, click the **procedure** added to the encounter. The Procedure Details window displays:

Procedure Details for Complete Colonoscopy For Foreign Body Removal

Unit of Service:

Modifier(s):

Comments:

☒ Appointed Provider: Role:

☐ Additional Provider #1: Role:

☐ Additional Provider #2: Role:

OK Cancel

Figure 9-12: Procedure Details Window

Note: You can also select a provider by clicking the Additional Provider drop-down arrow to display a list of providers. This provider list is the log in user's assigned clinic list.

2. Click the **ellipsis button** next to the Additional Provider #1 field. The Clinician Search window displays.

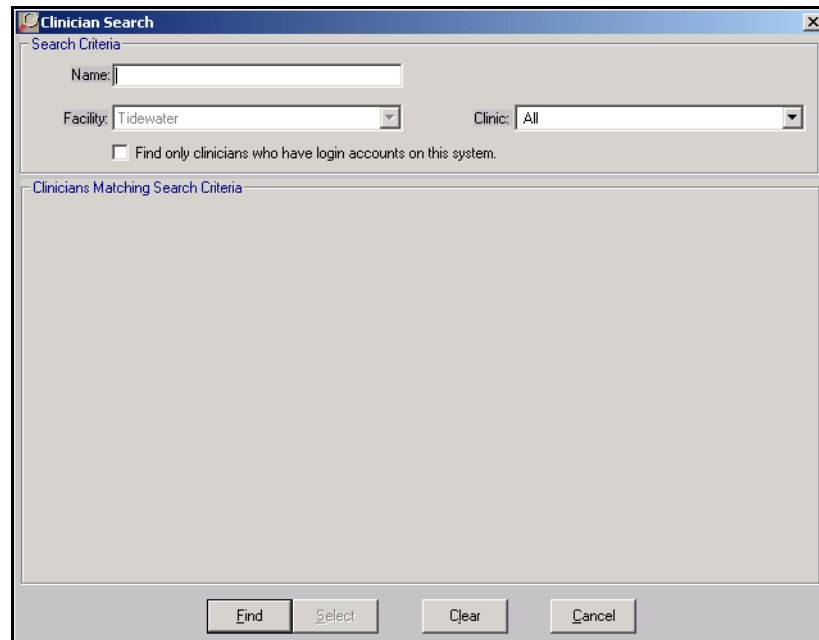


Figure 9-13: Clinician Search Window

3. In the **Last Name** field, enter the last name of the desired clinician.
4. Select a facility from the drop-down list.
5. Select a clinic from the drop-down list.
6. Click the **Find only clinicians who have login accounts on this system** to view only providers associated with CHCS II.
7. Click **Find**. The results are displayed in the bottom half of the Clinician Search window.
8. Select the desired clinician.
9. Click **Select**.
10. Click the drop-down arrow in the Roles field next to the Additional Provider #1 and select **Additional Provider Role**.

Figure 9–14: Selected Role

11. Click the checkbox next to the clinical team member who performed the procedure. Be sure to deselect the primary provider, as appropriate.
12. Click **OK**. The additional provider is now associated to the procedure.

9.7 Addressing Reminders

The Reminders tab enables you to view and address patient reminders. The reminders listed on the Reminders tab in A/P are the same reminders that are in the Reminder pane below the Folder List and those that are listed on the Due Reminders tab in the Wellness module. The Reminders tab in A/P helps to streamline the process to address these reminders. Reminders highlighted in yellow are due within 30 days and reminders highlighted in red are overdue.

Each reminder is associated with a default diagnosis and some with a default action. A full list of the default diagnoses and actions can be found in the Reminder Mapping module under the Tools folder on the Folder List. Once a reminder has been addressed, the default diagnosis is automatically added to the encounter and the default action is completed.

9.7.1 Viewing Reminders

When the Reminders tab is opened, the due reminders and immunizations that are overdue or are due in one month, display, based on the default filter.

Follow the steps below to change the list of reminders:

1. On the A/P module, click **Reminders**. The Reminders tab displays.
2. Set the Reminders filter, if desired, by making a selection from the drop-down list.

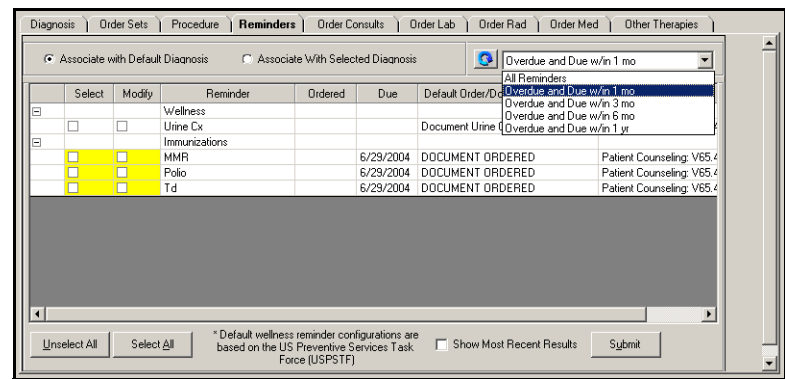


Figure 9–15: Reminders Tab—Drop-down List

3. Select the **Show Most Recent Results** checkbox to show the most recent results for the listed reminders. These are results from past lab and radiology orders or documented vital signs.

9.7.2 Addressing Reminders

Follow the steps below to address patient reminders:

1. On the A/P module, click **Reminders**. The Reminders tab displays.

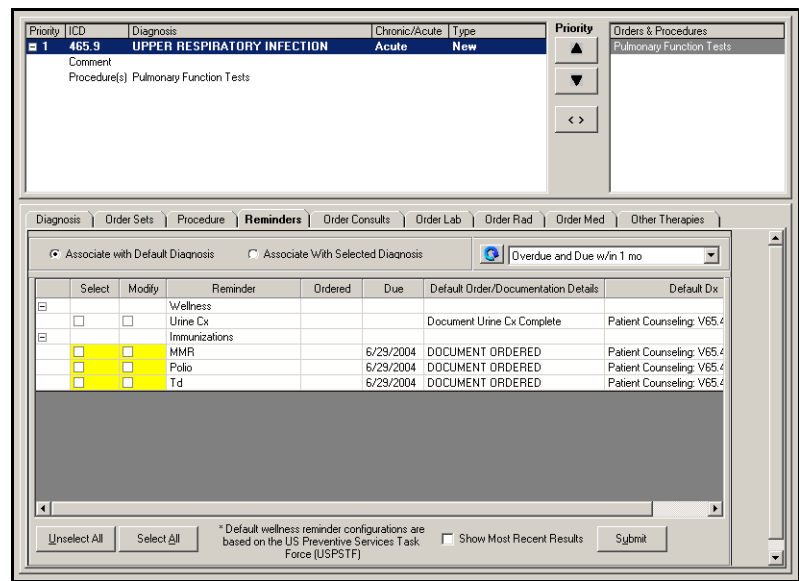


Figure 9–16: Reminders Tab

2. Click the checkbox in the Select column for those reminders that are to be addressed with no modifications.

Note: Click **Select All** to select all reminders. Click **Unselect All** to deselect all reminders.

Priority	ICD	Diagnosis	Chronic/Acute	Type
1	465.9	UPPER RESPIRATORY INFECTION	Acute	New
2	V65.40	Patient Counseling	Acute	New

Select	Modify	Reminder	Ordered	Due	Default Order/Documentation Details	Default Dx
<input type="checkbox"/>	<input type="checkbox"/>	Wellness			Document Urine Cx Complete	Patient Counseling: V65.4
<input type="checkbox"/>	<input type="checkbox"/>	Urine Cx				
<input type="checkbox"/>	<input type="checkbox"/>	Immunizations				
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	MMR		6/23/2004	DOCUMENT ORDERED	Patient Counseling: V65.4
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Polio		6/23/2004	DOCUMENT ORDERED	Patient Counseling: V65.4
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Td		6/23/2004	DOCUMENT ORDERED	Patient Counseling: V65.4

Figure 9–17: Reminders Tab

- If you want to associate the reminder with a different diagnosis than the default, select the diagnosis, and click the **Associate With Selected Diagnosis** radio button.
- Click **Submit**. The reminder is documented in the Diagnosis box under the associated diagnosis and any actions are completed.

Priority	ICD	Diagnosis	Chronic/Acute	Type
1	465.9	UPPER RESPIRATORY INFECTION	Acute	New

Select	Modify	Reminder	Ordered	Due	Default Order/Documentation Details	Default Dx
<input type="checkbox"/>	<input type="checkbox"/>	Wellness			Document Urine Cx Complete	Patient Counseling: V65.4
<input type="checkbox"/>	<input type="checkbox"/>	Urine Cx				
<input type="checkbox"/>	<input type="checkbox"/>	Immunizations				
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	MMR		6/23/2004	DOCUMENT ORDERED	Patient Counseling: V65.4
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Polio		6/23/2004	DOCUMENT ORDERED	Patient Counseling: V65.4
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Td		6/23/2004	DOCUMENT ORDERED	Patient Counseling: V65.4

Figure 9–18: Reminders Tab

9.7.2.1 Modifying a Reminder

Follow the steps below to modify and address a reminder:

- Click the checkboxes in the Select and Modify columns.

Priority	ICD	Diagnosis	Chronic/Acute	Type	Priority	Orders & Procedures
1	465.9	UPPER RESPIRATORY INFECTION	Acute	New		Pulmonary Function Tests

Select	Modify	Reminder	Ordered	Due	Default Order/Documentation Details	Default Dx
<input type="checkbox"/>	<input type="checkbox"/>	Wellness				
<input type="checkbox"/>	<input type="checkbox"/>	Urine Cx			Document Urine Cx Complete	Patient Counseling: V65.4
<input type="checkbox"/>	<input type="checkbox"/>	Immunizations				
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Hep A		6/29/2004	DOCUMENT ORDERED	Patient Counseling: V65.4
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	MMR		6/29/2004	DOCUMENT ORDERED	Patient Counseling: V65.4
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Polio		6/29/2004	DOCUMENT ORDERED	Patient Counseling: V65.4
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Td		6/29/2004	DOCUMENT ORDERED	Patient Counseling: V65.4
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Yellow Fever		6/29/2004	DOCUMENT ORDERED	Patient Counseling: V65.4

☒ Associate with Default Diagnosis
 ☐ Associate With Selected Diagnosis
 Overdue and Due w/in 1 mo

* Default wellness reminder configurations are based on the US Preventive Services Task Force (USPSTF)
 ☐ Show Most Recent Results

Figure 9–19: Reminders Tab—Select and Modify

- If you want to associate the reminder with a different diagnosis than the default, select the diagnosis, and click the **Associate With Selected Diagnosis** radio button.
- Click **Submit**. The reminder is documented.

Note: To edit the comments, click **Comment** under the appropriate diagnosis.

The screenshot shows the 'Reminders' tab in a software interface. At the top, there is a table with columns: Priority, ICD, Diagnosis, Chronic/Acute, and Type. The first row shows Priority 1, ICD 465.9, Diagnosis UPPER RESPIRATORY INFECTION, Chronic/Acute Acute, and Type New. The second row shows Priority 2, ICD V65.40, Diagnosis Patient Counseling, Chronic/Acute Acute, and Type New. Below this table is a comment: 'MMR Ordered. This is a comment associated with the MMR immunization'. To the right of the table is a 'Priority' section with up, down, and left/right arrow buttons. Below the table is a section for 'Orders & Procedures' with a list of 'Pulmonary Function Tests'. Below this is a section for 'Diagnosis', 'Order Sets', 'Procedure', 'Reminders', 'Order Consults', 'Order Lab', 'Order Rad', 'Order Med', and 'Other Therapies'. The 'Reminders' tab is selected. Below this is a section for 'Associate with Default Diagnosis' and 'Associate With Selected Diagnosis'. Below this is a table with columns: Select, Modify, Reminder, Ordered, Due, Default Order/Documentation Details, and Default Dx. The table lists various reminders: Wellness, Urine Cx, Immunizations, Hep A, MMR, Polio, Td, and Yellow Fever. The 'Immunizations' section is expanded, showing details for each vaccine. At the bottom, there are buttons for 'Unselect All', 'Select All', 'Show Most Recent Results', and 'Submit'. A note at the bottom states: '* Default wellness reminder configurations are based on the US Preventive Services Task Force (USPSTF)'.

Figure 9-20: Reminders Tab—Immunizations Documented

Note: The immunizations Reminders continue to persist until the appropriate action of vaccination is taken in the Immunization module.

9.8 Ordering a Consult

The Order Consults tab allows you to enter a consult request for a specific encounter. Follow the steps below to order a consult:

1. Click the Order Consults tab. The Order Consults tab displays.

The screenshot shows the 'Order Consults' tab in a software interface. At the top, there is a table with columns: Priority, ICD, Diagnosis, Chronic/Acute, and Type. The first row shows Priority 1, ICD 465.9, Diagnosis UPPER RESPIRATORY INFECTION, Chronic/Acute Acute, and Type New. Below this table is a comment: 'MMR Ordered. This is a comment associated with the MMR immunization'. To the right of the table is a 'Priority' section with up, down, and left/right arrow buttons. Below the table is a section for 'Orders & Procedures' with a list of 'Pulmonary Function Tests'. Below this is a section for 'Diagnosis', 'Order Sets', 'Procedure', 'Reminders', 'Order Consults', 'Order Lab', 'Order Rad', 'Order Med', and 'Other Therapies'. The 'Order Consults' tab is selected. Below this is a section for 'Consulting Network' with radio buttons for 'Military / Tricare (SF 513)' and 'Civilian (DD 2161)'. Below this is a section for 'Refer To' with a dropdown menu. Below this is a section for 'Specialty' with a dropdown menu. Below this is a section for 'Clinic' with a dropdown menu. Below this is a section for 'Reason For Request' with a dropdown menu. Below this is a section for 'Consulting Provider' with a dropdown menu. Below this is a section for 'Consulting Provider's Duty Phone' with a dropdown menu. Below this is a section for 'Priority' with a dropdown menu. Below this is a section for 'Output Method' with a dropdown menu. Below this is a section for 'Provisional Diagnosis' with a dropdown menu. Below this is a section for 'Active Consults' with a table with columns: Date Ordered, Primary Dx, Referring Provider, Recipient, Status, and Netwc. At the bottom, there are buttons for 'Clear', 'Save As Draft', 'Sign', and 'Submit'. A note at the bottom states: '* Default wellness reminder configurations are based on the US Preventive Services Task Force (USPSTF)'.

Figure 9-21: A/P Order Consults Tab

2. When placing an order for a consult, complete the required fields:

Note: The system requires an entry or selection for each field except phone.

- **Consulting Network:** Select the appropriate radio button. The Consulting Network group of radio buttons includes Military/TRICARE (SF513) and Civilian (DD2161). The default is Military/TRICARE Medical Care (SF513).
- **Refer To:** Select the recipient of the consult from the drop-down list. The associated specialty or clinic is automatically displayed in the corresponding fields.
- **Specialty:** This field defaults with the associated specialty from the item selected in **Refer To**.
- **Clinic:** This field defaults with the associated clinic from the item selected in **Refer To**.
- **Reason for Request:** The system enables the referring provider to enter a free-text description. Click inside the text box and type the reason.
- **Provisional Diagnosis:** A provisional diagnosis is the referring provider's best estimate of the patient's actual diagnosis. Often the patient is being referred because the diagnosis is uncertain, hence Provisional. If the Diagnosis code has been completed, it automatically populates the Provisional Diagnosis field. If the diagnosis has not been documented, enter the provisional diagnosis in the Provisional Diagnosis field.

Note: CHCS II defaults the provisional diagnosis field to the diagnosis selected.

- **No (Number) of Visits:** This number refers to the recommended number of visits to complete the consult. Enter the desired number.
 - **Referral Authorized until:** The date until which this consult order is active. It is pre-filled with a date 30 days from the current date. Enter the appropriate date.
 - **Consulting Provider:** Select the consulting provider from the drop-down list.
 - **Priority:** Select the desired priority from the drop-down list.
 - **Output Method:** Select an output method from the drop-down list. The Output Method refers to how the results of the consult should be communicated. The choices include Send Electronically Only, Send and Print, and Print Only. The default is Send Electronically Only.
 - **Consulting Provider's Duty Phone:** If a clinic provider was selected, the phone number displays here. The number is taken from information entered during the initial registration.
3. After you enter the required information, click one of the following:
- **Submit:** The system submits the newly created consult orders to CHCS for routing and scheduling with the selected specialty. The status is then changed

to Submitted. The consult is also added to the Assessment and Planning module in the upper right corner with the list of procedures and is associated with the highlighted diagnosis. Highlight the desired diagnosis and double-click the consult to re-associate the consult with a different diagnosis.

- **Save As Draft:** The consult request status is saved in draft form because the request has not been submitted and can be edited.
- **Clear:** Cancels the information entered for the consult.

Priority	ICD	Diagnosis	Chronic/Acute	Type	Orders & Procedures
1	465.9	UPPER RESPIRATORY INFECTION	Chronic	Follow-Up	Pulmonary Function Tests Peak Flow NMCP Allergy, UPPER RESPIRATORY INFECTION

Figure 9-22: Added Consults

9.8.1 Managing Active Consults

The Active Consults area at the bottom of the workspace lists consults by other providers for this patient as well as the ones ordered by you. The statuses for these consults include the following:

- Pending Results
- Updated
- Draft
- Pending Appointment
- Pending Review

Active consults can be edited, copied as new, or deleted. You can also view the history of the consult to track its progress through the workflow.

Follow the steps below to edit or copy the consult:

1. Select the consult from the Active Consults list.
2. Perform a right mouse click and select either **Edit** or **Copy as New**. The consult fields are populated with the details from the active consult.
3. Make any necessary changes and click **Submit**.

Follow the steps below to delete an active consult:

1. Select the consult from the Active Consult list.
2. Perform a right mouse click and select **Delete**. The consult is deleted from the Active Consults list.

Follow the steps below to view the history of a consult:

1. Select the consult from the Active Consult list.
2. Perform a right mouse click and select **History**. The Consult History window opens.

- Review the history and click **OK** to return to the A/P module.

9.9 Ordering a Laboratory Test

The Order Lab tab allows you to enter a laboratory test for a specific encounter in the A/P module.

Follow the steps below to order laboratory tests:

- Click the Order Lab tab. The Order Lab tab displays.

Figure 9–23: A/P Order Lab Tab

- Complete the following sections:
 - Search:** Enter the name of the desired lab test and click **Search**. The results populate the Lab Test Name drop-down list.
 - Lab Section:** Select the departments for the desired procedure. This narrows the results of the search, but is not necessary. Select **All Sections** to see all available departments.
 - Lab Test Name:** The results of the search populate the drop-down list. Select the desired laboratory test.

Note: If the pre-verify process identifies any conflicts regarding the order, the Lab Override window opens. Type a reason for the override in the Warnings window and click **Accept Override** to override the warning message. Click **Cancel Order** and select an alternative order to ignore the warning override.

One Drug Order warning returned

Order: AMOXICILLIN 250MG--PO 250MG CAP

1) Allergic Reaction Class
Patient allergies to: PENICILLINS; CEPHALOSPORINS; CARBAPENEM

Count: 1
Type: Drug Order

Specify a reason for this override:

Accept Override Cancel Order

Figure 9-24: Lab Override Window

Note: The CHCS pre-verify process also identifies the laboratory test specimen, type, and container requirements. If there is more than one option, the Lab Collection Choices window opens and allows you to select preferences.

Lab Collection Choices: [MONONUCLEOSIS SCREEN]

Choose a COLLECTION SAMPLE

Choices for Collection Sample and Type

Collection Sample	Specimen-Type	Container
BLOOD	PLASMA	LAVENDER

Search for specimen-type

Search keyword

Search

Results of specimen-type search

Collection results for the order screen:

SAMPLE: BLOOD
CONTAINER: LAVENDER
COMMENT: COLLECT 4-7 CC BLOOD IN SST OR LAVENDER TOP TUBE

OK

STATUS

Figure 9-25: Lab Collection Choices Window

- **Showing Panel Contents:** If a laboratory test is associated with two or more subtests, the **Show Items in Panel** button is enabled. Click the button to display the Lab Panel Elements window for the selected laboratory test. Click **OK** to return to the Lab Orders tab.

- **Processing Priority:** Click the radio button in the Processing Priority area to select a different processing priority. Options include Routine, ASAP, STAT, Notify, and Preop.
- **Comments or Instructions:** In the **Comments** field, enter comments.

Note: Lab free-text persists in the Comments field during an Order Entry session.

- **Show Collection Choices:** If a laboratory test has two or more collection options, the Lab Collection Choices window opens displaying the available choices. Click **Show Collection Choices** to select specimen collection methods.
 - **More Detail:** Click **More Detail** to view options for Schedule, Collection Priority, Collection Method, and Requesting Location. Once you click **More Detail**, the button changes to Less Detail.
 - **Schedule:** Click the **One-Time** or **Continuous** radio button. The default is One-Time and Continuous is grayed out if the option is not appropriate for the selected test. If **Continuous** is selected, the Timing, Start Date, Frequency, and Duration fields become active. These fields have default values depending on the test selected.
 - **Timing:** Use the drop-down list to change the time.
 - **Start Date:** In the **Start** field, enter the desired date (or use the arrow keys in the field to select a date). The start date may only be the current date or a date in the future.
 - **Frequency (for Continuous tests only):** Use the drop-down list to change the frequency.
 - **Duration (Days) (for Continuous tests only):** In the **Duration (Days)** field, enter the preferred number of days.
 - **Collection Priority:** Use the drop-down list to select a priority. The default is Routine.
 - **Collection Method:** Use the drop-down list to select a collection method. The default is Send Patient to Lab.
 - **Requesting Location:** Use the drop-down list to select a requesting location. The default is the location of the workstation.
3. Do one of the following:
- If all necessary information has been added and you want to submit the order, click **Submit**. The order is seen in the Outstanding Laboratory Orders area.
 - If you are not ready to submit the order, or if you have other orders you need to add before submitting, Click **Save to Queue**. This saves the order so you can submit it later.

Note: If the order is underlined, it is in a queue and has not been submitted. If the order is underlined and bolded, it is in a queue but has not been associated

with a diagnosis or submitted. Click **Submit All** to submit orders in a queue. Orders without a diagnosis cannot be submitted unless you add a diagnosis.

Note: Select the desired diagnosis and double-click the lab order to associate an order with a diagnosis.

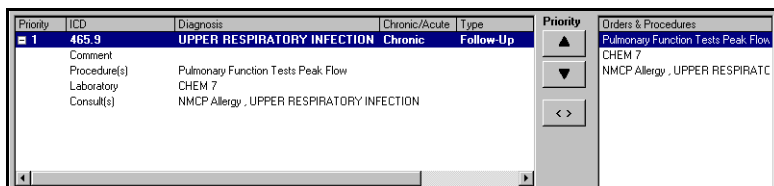


Figure 9–26: Added Laboratory Test

9.9.1 Anatomic Pathology Worksheets

Anatomic Pathology worksheets display for lab tests requiring additional pathology information than what is needed for ordering other lab tests. The worksheet displays when you search for a specified anatomic pathology lab test on the Order Labs tab in the A/P module. There are five Anatomic Pathology worksheets:

- Autopsy
- Bone Marrow
- Cytologic Gyn
- Cytologic Non-Gyn
- Tissue Exam

Note: The results for ordered Anatomic Pathology tests can be viewed in the Clinical Notes module. Open the Clinical Notes module for the selected patient to view results. Click **Filter** to access the Filter tab on the Properties window and select **Specific Note Types**. Click **Add** to access the Healthcare Data Dictionary Search for Clinical Note Types and search for Anatomical Pathology Reports. Add this as your filter to view results for ordered anatomic pathology tests.

9.9.1.1 Completing Autopsy Worksheets

The Autopsy Worksheet window appears when you order an anatomic pathology lab test in the A/P module.

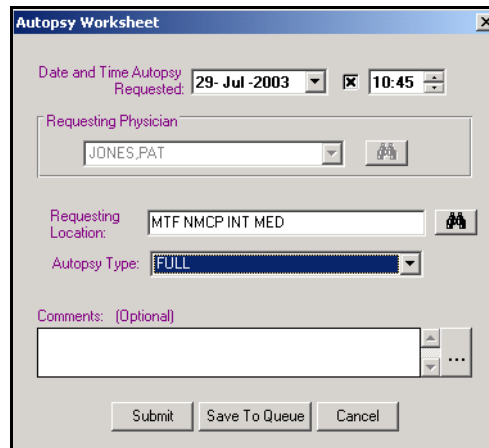


Figure 9-27: Autopsy Worksheet

Follow the steps below to complete an Autopsy worksheet:

1. Select a date and time for the requested autopsy. The current date and time are defaulted to the user's workstation date and time, and the checkbox is automatically selected.
2. Select the **Requesting Location** from the drop-down list. The location defaults to your selected clinic.
3. Select the **Autopsy Type** being performed from the drop-down list.
4. If necessary, enter any comments in the **Comments** field.
5. If all necessary information has been added and you want to submit the order, click **Submit**.
 - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order allowing you to submit it at a later time.

9.9.1.2 Completing Bone Marrow Worksheets

The Bone Marrow Worksheet window appears when you order an anatomic pathology lab test in the A/P module.

Bone Marrow Worksheet

Specimen Collection Date and Time: 29-Jul-2003 10:46

Processing Priority: ☒ Routine ☐ ASAP ☐ STAT ☐ Notify ☐ Preop

Requesting Location: MTF NMCP INT MED

Ordering Provider: JONES.PAT

Specimen Entry

Container: A Frozen? ☒ No ☐ Yes

Description: [Text Area] Add

Specimen List

#	Container	Description	Frozen

Modify Delete Delete ALL

Clinical History (BRIEF): [Text Area] ...

PreOp Diagnosis: [Text Area] ...

Operative Findings: [Text Area] ...

PostOp Diagnosis: [Text Area] ...

Submit Save To Queue Cancel

Figure 9–28: Bone Marrow Worksheet

Follow the steps below to complete a bone marrow worksheet:

1. Select a date and time for the bone marrow specimen collection. The current date and time are defaulted to the user's workstation date and time, and the checkbox is automatically selected.
2. Select the **Processing Priority** for the specimen. Routine is selected as the default priority.
3. Select the **Requesting Location** from the drop-down list. The location defaults to your selected clinic.
4. Enter the container label and description for the specimen being collected. If the specimen is frozen, select **Yes**.
5. Click **Add**.

Note: The specimen information displays in the Specimen List area. You can modify or delete specific information, if necessary.

6. Enter a brief clinical history for the specimen.
7. Enter a brief PreOp diagnosis for the specimen.

8. If all necessary information has been added and you want to submit the order, click **Submit**.
 - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order allowing you to submit it at a later time.

9.9.1.3 Completing Cytologic Gyn Worksheets

The Cytologic Gyn Worksheet window appears when you order an anatomic pathology lab test in the A/P module.

Figure 9–29: Cytologic Gyn Worksheet

Follow the steps below to complete a Cytologic Gyn worksheet:

1. Select a date and time for the cytologic gyn specimen collection. The current date and time are defaulted to the user's workstation date and time, and the checkbox is automatically selected.
2. Select a **Specimen** from the drop-down list.
3. Select the **Processing Priority** for the specimen. Routine is selected as the default priority.
4. Select the **Requesting Location** from the drop-down list. The location defaults to your selected clinic.
5. Indicate whether the patient is taking any of the following:

- Birth Control Pills
 - IUD
 - Post-Menopausal
 - Hysterectomy
 - Hormone Therapy
6. If the patient is pregnant or recently gave birth, select the number of weeks from the drop-down list.
 7. Indicate the start dates for any of the following:
 - Last Menses
 - Radiation Therapy
 - Cytotoxic Therapy
 8. Enter any related results or previous cytology diagnoses.
 9. Enter any related cytology comments.
 10. If all necessary information has been added and you want to submit the order, click **Submit**.
 - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order allowing you to submit it at a later time.

9.9.1.4 Completing Cytologic Non-gyn Worksheets

The Cytologic Non-gyn Worksheet window appears when you order an anatomic pathology lab test in the A/P module.

Cytologic Non-gyn Worksheet

Specimen Collection Date and Time: 29-Jul-2003 10:47

Processing Priority: ☒ Routine ☐ ASAP ☐ STAT ☐ Notify ☐ Preop

Requesting Location: MTF NMCP INT MED

Ordering Provider: JONES.PAT

Specimen Entry

Container: A Frozen? ☒ No ☐ Yes

Description: Add

Specimen List

#	Container	Description	Frozen

Modify Delete Delete ALL

Clinical History (BRIEF):

PreOp Diagnosis:

Operative Findings:

PostOp Diagnosis:

Submit Save To Queue Cancel

Figure 9-30: Cytologic Non-gyn Worksheet

Follow the steps below to complete a Cytologic Non-Gyn worksheet:

1. Select a date and time for the cytologic non-gyn specimen collection. The current date and time are defaulted to the user's workstation date and time, and the check-box is automatically selected.
2. Select the **Processing Priority** for the specimen. Routine is selected as the default priority.
3. Select the **Requesting Location** from the drop-down list. The location defaults to your selected clinic.
4. Enter the container label and description for the specimen being collected. If the specimen is frozen, select **Yes**.
5. Click **Add**.

Note: The specimen information displays in the Specimen List area. You can modify or delete specimen information, as necessary.

6. Enter related Clinical History information for the specimen.
7. Enter related PreOp diagnoses for the specimen.
8. Enter related Operative Findings for the specimen.

9. Enter related PostOp diagnoses for the specimen.
10. If all necessary information has been added and you want to submit the order, click **Submit**.
 - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order allowing you to submit it at a later time.

9.9.1.5 Completing Tissue Exam Worksheets

The Tissue Exam Worksheet window appears when you order an anatomic pathology lab test in the A/P module.

Tissue Exam Worksheet

Specimen Collection Date and Time: 29-Jul-2003 10:48

Processing Priority: ☒ Routine ☐ ASAP ☐ STAT ☐ Notify ☐ Preop

Requesting Location: MTF NMCP INT MED

Ordering Provider: JONES, PAT

Specimen Entry

Container: A Frozen? ☒ No ☐ Yes

Description: [Text Field] Add

Specimen List

#	Container	Description	Frozen

Modify Delete Delete ALL

Clinical History (BRIEF): [Text Field] ...

PreOp Diagnosis: [Text Field] ...

Operative Findings: [Text Field] ...

PostOp Diagnosis: [Text Field] ...

Submit Save To Queue Cancel

Figure 9–31: Tissue Exam Worksheet

Follow the steps below to complete a tissue exam worksheet:

1. Select a date and time for the tissue specimen collection. The current date and time are defaulted to the user's workstation date and time, and the checkbox is automatically selected.
2. Select the **Processing Priority** for the specimen. Routine is selected as the default priority.
3. Select the **Requesting Location** from the drop-down list. The location defaults to your selected clinic.

4. Enter the container label and description for the specimen being collected. If the specimen is frozen, select **Yes**.
5. Click **Add**.

Note: The specimen information displays in the Specimen List area. You can modify or delete specimen information, as necessary.

6. Enter related Clinical History information for the specimen.
7. Enter related PreOp diagnoses for the specimen.
8. Enter related Operative Findings for the specimen.
9. Enter related PostOp diagnoses for the specimen.
10. If all necessary information has been added and you want to submit the order, click **Submit**.
 - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order allowing you to submit it at a later time.

9.10 Ordering a Radiology Procedure

The Order Rad tab allows you to order a radiology procedure for a specific encounter. Follow the steps below to order a radiology procedure in the A/P module:

1. Click the Order Rad tab. The Order Rad tab displays.

Figure 9–32: A/P Order Rad Tab

2. Complete the following fields:

- **New Rad Order:** In the Search field, enter the name of the desired radiology test and click **Search**. The results populate the Procedure Name drop-down list.
- **Rad Section:** Select the departments for the desired procedure from the drop-down list. This narrows the results of the search but is not necessary. Select **All Sections** to see all available departments.

Note: The pre-verify process identifies and displays warnings regarding the Radiology order. Type a reason for the override in the Warnings window and click **Accept Override** to override the warning. Otherwise, click **Cancel Order** and select an alternative order.

- **Procedure Name:** Select the desired test from the drop-down list.
- **Clinical Impression:** Enter the reason(s) for ordering the radiology procedure. This is a mandatory field.

Note: The previous clinical impression can carry over to the next radiology order by selecting **Yes** in the dialog box.

- **Priority:** Click the radio button in the Processing Priority area to select a different processing priority. Options include Routine, ASAP, STAT, Notify, and Preop.
- **Immediate Reading:** Click the **Immediate Reading** check box to denote that the test should be read immediately.
- **Comments or Instructions:** Enter any comments or instructions related to the radiology procedure.
- **More Detail:** Click **More Detail** to view options for Schedule, Patient Mobility, and Requesting Location. After you click **More Detail**, the button changes to **Less Detail**.
- **Schedule:** Select **one-time** or **continuous**.

Note: **Timing**, **Frequency** and **Duration** are only available if the continuous radio button is checked in **Schedule**.

- **Timing:** Select either **AM** or **HS** from the drop-down list.
- **Start Date:** Click the drop-down arrow to open the calendar window. Select the start date.
- **Frequency:** Click the drop-down list and select the frequency.
- **Duration (Days):** Enter the duration.
- **Patient Mobility:** Select the option that best defines the patient's mobility from the drop-down list.

- **Requesting Location:** Select a requesting location from the drop-down list. The default is the location of the workstation.
3. Do one of the following:
- If all necessary information has been added and you want to submit the order, click **Submit**. The order is seen in the Outstanding Radiology Orders area.
 - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order, allowing you to submit it at a later time.

Note: If the order is underlined, it is in a queue and has not been submitted. If the order is underlined and bolded, it is in a queue but has not been associated with a diagnosis or submitted. Click **Submit All** to submit orders in a queue. Orders without a diagnosis cannot be submitted unless you add a diagnosis.

Note: Select the desired diagnosis and double-click the procedure to associate the procedure to a diagnosis.

Priority	ICD	Diagnosis	Chronic/Acute	Type	Orders & Procedures
1	465.9	UPPER RESPIRATORY INFECTION	Chronic	Follow-Up	Pulmonary Function Tests Peak Flow CHEM 7 CHEST, PA AND LATERAL NMCP Allergy . UPPER RESPIRATC

Figure 9–33: Added Radiology Test

9.11 Ordering a Medication

As you submit an outpatient medication order, the order is verified in CHCS to ensure that you have the proper privileges and that the selected medication is available. You can submit new orders and modify, renew, discontinue or change the status of previously processed orders. CHCS validates each order as it is submitted and alerts you to any requirements (such as co-signature required) or limiting circumstances (such as availability or patient allergies).

Follow the steps below to order a medication:

1. Click the Order Med tab. The Order Med tab displays.

Figure 9-34: A/P Order Med Tab

2. Complete the following sections:

- **New Med Order:** In the **Search** field, enter the medication name and click **Search**. The results populate the Item Name drop-down list.
- **Item Name:** Select the desired medication from the drop-down list populated by the search function.
- **SIG:** Enter a new SIG or use the one returned by the pre-verify process. If you follow the SIG with a number preceded with the number sign (e.g. #30), and press the <Enter> key, the Quantity field is populated with the number you entered. Click **Expand SIG** to view an expanded version of the displayed SIG code. The expanded **SIG** field provides a detailed explanation of the SIG codes returned from CHCS.
- **Quantity:** Enter the quantity to be dispensed. Use the unit of measure shown in the **Default Unit** field on the right side of the tab or the quantity shown with the name/description of the medication. Default = 30-days' supply, calculated from the **SIG**, **Quantity**, and **Refill** fields.
- **Refills:** Enter the number of refills. (Look in the **Maximum** field for the maximum number of refills allowed.) An error message displays if the number of refills is greater than the maximum (Maximum = maximum number of days' supply allowed).
- **Start Date:** Enter the date the medication is to start (or use the arrow cursor in the field to select a date). The start date can only be the current date or a date in the future.
- **Child Resistant Cap:** If you do not want a child resistant cap, deselect **Child Resistant Cap**.
- **Comment:** Enter comments you want associated with the medication.

- **More Detail:** Click **More Detail** to view options for the dispensing and requesting locations. After clicking **More Detail**, the button changes to **Less Detail**.
 - **Requesting Location:** Select a requesting location from the drop-down list. The default is the location of the workstation.
 - **Dispensing Location:** This field defaults to the associated pharmacy. Use the drop-down list to select another location.
3. Do one of the following:
- If all necessary information has been added and you want to submit the order, click **Submit**. You can see the order in the Current Outpatient Medications area.
 - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order allowing you to submit it at a later time.

CHCS pre-verifies the order against patient and medications records and displays any resulting messages or warnings, as well as any SIG code(s) and standard order/refill quantities associated with the medication. In addition, CHCS II now provides connectivity to the Pharmacy Data Transaction System (PDTS), a central data repository containing patient medication profiles for all beneficiaries. In order entry—meds, in the Assessment and Plan module, PDTS provides the CHCS II user with:

- Excessive and insufficient dose warnings
- Interaction, overlap and duplicate warnings, and warning override capabilities
- Warning overrides on renew and modify orders

If the pre-verify process identifies warnings regarding the order, the CHCS and PDTS warnings display in the same window. Select a reason for override with the **Warning Override Reasons** radio buttons to override the warning. Select a radio button under the **Order Cancellation Reasons** to cancel an order.

Figure 9–35: CHCS and PDTs Warning Window

Note: If the order is underlined, it is in a queue and has not been submitted. If the order is underlined and bolded, it is in a queue but has not been associated with a diagnosis or submitted. Click **Submit All** to submit orders in a queue. Orders without a diagnosis cannot be submitted unless you add a diagnosis.

Note: Select the desired diagnosis and double-click the order to associate the order with a diagnosis.

Figure 9–36: Added Medications

9.12 Requesting Location

Follow the steps below to select a requesting location:

1. Click the **More Detail** button.

The screenshot shows the 'Order Med' tab in a medical software interface. At the top, there is a table with columns: Priority, ICD, Diagnosis, Chronic/Acute, Type, Priority, and Orders & Procedures. The first row shows '1', '465.9', 'UPPER RESPIRATORY INFECTION', 'Acute', 'New', a triangle icon, and 'Pulmonary Function Tests'. Below this table, there is a 'Comment' field with the text 'Pulmonary Function Tests'. To the right of the comment field are three buttons: a triangle icon, a square icon, and a '< >' icon. Below the comment field is a section for 'Patient's Weight: 170.00 lbs; 77.11 kg'. This section contains a 'New Med Order' form with fields for 'Item Name', 'SIG', 'Qty', 'Max', 'Days Supply', 'Default Unit', 'Refills', and 'Start Date'. There is also a 'Note to Provider' field, a 'Dispensing Location' dropdown menu (set to 'PROVIDER ORDER ENTER'), and a 'Comments (Optional)' field. At the bottom of this section are buttons for 'More Detail...', 'Clear', 'Save To Queue', and 'Submit'. Below the 'New Med Order' form is a table for 'Current Outpatient Medications' with columns: Description, Last Fill..., Refills..., Status, Order Expi..., Sig Ne..., and Order ID. At the very bottom are buttons: 'New', 'Discontinue', 'Renew', 'Renew + Modify', 'Modify', 'Hold', 'Show Detail', 'Sign', 'Refresh List', and 'Do Not Show Orders'.

Figure 9-37: Order Med Tab

- Click the **Search** icon. The Find Requesting Location window opens.

This screenshot shows the 'Order Med' tab with the 'More Detail' window open. The 'New Med Order' form is visible, but the 'Search' button is highlighted. The 'Expanded SIG' field is now populated with '29-Jun-2004'. The 'Requesting Location' dropdown menu is set to 'SILVER MTF'. The 'Ordering Provider' dropdown menu is set to 'SMITH, JACOB'. The 'Child-Resistant Cap' checkbox is checked. The 'Current Outpatient Medications' table is also visible at the bottom.

Figure 9-38: More Detail

The 'Find Requesting Location' window is shown. It has a title bar with the text 'Find Requesting Location'. Inside, there is a 'Search Keyword' field and a 'Location Type' dropdown menu (set to 'ALL'). A 'Search' button is to the right of the dropdown. Below these fields is a 'Results' section containing a table with three columns: 'Name', 'Type', and 'MEPRS Code'. The table is currently empty. At the bottom of the window are 'OK' and 'Cancel' buttons.

Figure 9-39: Find Requesting Location Window

3. If necessary or desired you may refine a search by making a selection from the Location Type drop-down list in conjunction with entering a search string.

Find Requesting Location

Search Keyword:

Location Type:

Search

Results:

Name	Type	MEPRS Code

OK Cancel

Figure 9-40: Location Type Drop-down List

4. Alternatively, enter a search string and click the **Search** button. The search results display.

Find Requesting Location

Search Keyword:

Location Type:

Search

Results:

Name	Type	MEPRS Code
WOMEN'S HEALTH CLINIC	CLINIC	BCBA

OK Cancel

Figure 9-41: Search Results Displayed

5. Select the desired search results and click **OK**. The selected Requesting Location display in the **Requesting Location** field.

Diagnosis | Order Sets | Procedure | Reminders | Order Consults | Order Lab | Order Rad | **Order Med** | Other Therapies

Patient's Weight: 170.00 lbs; 77.11 kg

New Med Order [Search]

Item Name: [Dropdown] [Expand SIG]

SIG: [Text]

Qty: [Text] Max: [Text] Days Supply: [Text] Default Unit: [Text]

Refills: [Text] Default: [Text] Maximum: [Text] Start Date: 29-Jun-2004

Expanded SIG: [Text]

Ordering Provider: SMITH, JACOB [Dropdown] [Icon]

Current Outpatient Medications

Description: [Text] Last Fill: [Text] Refills: [Text] Status: [Text] Order Expi: [Text] Sig Ne: [Text] Order ID: [Text]

Note to Provider: [Text]

Dispensing Location: PROVIDER ORDER ENTER [Dropdown] [Default]

Comments: (Optional) [Text]

Less Detail... Clear Save To Queue Submit

Requesting Location: REMOTE LAB, SEYMOUR [Dropdown] [Icon]

☒ Child-Resistant Cap

Figure 9-42: Requesting Location Field Populated

9.13 Adding Patient Instructions

The Other Therapies tab allows you to add patient instructions for a specific encounter. The instructions should be associated with selected diagnoses or procedures. They are not associated with patient handouts that may be provided to the patient.

Follow the steps below to enter other therapies:

1. On the A/P module, click **Other Therapies** to view the Other Therapies tab.

Priority	ICD	Diagnosis	Chronic/Acute	Type
1	465.9	UPPER RESPIRATORY INFECTION	Acute	New
2	V65.40	Patient Counseling:	Acute	New
		Comment: MMR Ordered. This is a comment associated with the MMR immunization		

Priority: [Dropdown] [Up] [Down] [Left] [Right]

Orders & Procedures: Pulmonary Function Tests

Diagnosis | Order Sets | Procedure | Reminders | Order Consults | Order Lab | Order Rad | Order Med | **Other Therapies**

<< >> Order Set template [Dropdown] Search [Text] Find Now

Description: [Text]

Add

Figure 9-43: A/P Other Therapies Tab

2. Patient Instructions may be selected using the following methods:
 - Template List (see online help for descriptions)
 - Search (see online help for descriptions)

3. Select the instructions you want to add to the encounter.

Note: Instructions with a plus sign (+) next to them can be expanded to view associated instructions at a lower level. A minus sign (-) next to the instruction indicates the instruction is at the lowest level.

4. Click **Add**.

The instruction is added to the Orders and Procedures area and is associated with the selected diagnosis.

- Follow the steps below to associate the order with a different diagnosis:
 - a. In the diagnosis list, select the instruction under the associated diagnosis.
 - b. Click the **Associates/Unassociates Orders & Procedures** icon.
 - c. Select the instruction and the diagnosis, and click the **Associates/Unassociates Orders & Procedures** icon to associate the instruction with the alternative diagnosis.

5. On the Action bar, click **Close**. The completed A/P is AutoCited in the Patient Encounter module.

Tip:

If the instruction was not automatically associated to the diagnosis, highlight the appropriate diagnosis and select the instruction.

Multiple instructions can be added using the same procedure.

9.14 Discontinuing an Order

Follow the steps below to discontinue an order:

1. From the Current Orders workspace at the bottom of any of the order entry tabs (Order Lab, Order Rad, Order Med), click **Show Orders**.
2. Select the order.
3. Click **Discontinue**.

9.15 Placing an Order on Hold

Follow the steps below to place an order on hold:

1. From the Current Orders workspace at the bottom of any of the order entry tabs (Order Lab, Order Rad, Order Med), click **Show Orders**.
2. Select the order.
3. Click **Hold**. The status of the order changes to Hold.

9.16 Showing the Details of an Order

Follow the steps below to show details of an order:

1. From the Current Orders workspace at the bottom of any of the order entry tabs (Order Lab, Order Rad, Order Med), click **Show Orders**.
2. Select an order.

3. Click **Show Detail** to view the Detail window.
4. Click **OK** to return to the Order Entry tab.

9.17 Renewing/Modifying an Order

Follow the steps below to renew an order:

1. From the Current Orders workspace at the bottom of any of the order entry tabs (Order Lab, Order Rad, Order Med), click Show Orders.
2. Select the order.
3. Click **Renew**. The Enter Reason For Action window opens.
4. Enter your reason for renewing the order.
5. Click **OK** to return to the Order Entry tab.
6. Click **Submit**.

Follow the steps below to modify an order:

1. From the Current Orders workspace at the bottom of any of the order entry tabs (Order Lab, Order Rad, Order Med), click Show Orders.
2. Select the order.
3. Click **Modify**. The Enter Reason For Action window opens.
4. Enter your reason for modifying the order.
5. Click **OK** to return to the Order Entry tab.
6. Click **Submit**.

Note: Click **Renew** + **Modify** to renew and modify an order.

10.0 CLINICAL NOTES

10.1 Clinical Notes Overview

The Clinical Notes module displays patient-specific notes that are not associated with an encounter, including those that have been imported from non-CHCS II system text notes. Clinical Notes can be copied into the Add Note portion of the Encounter Summary (SF600).

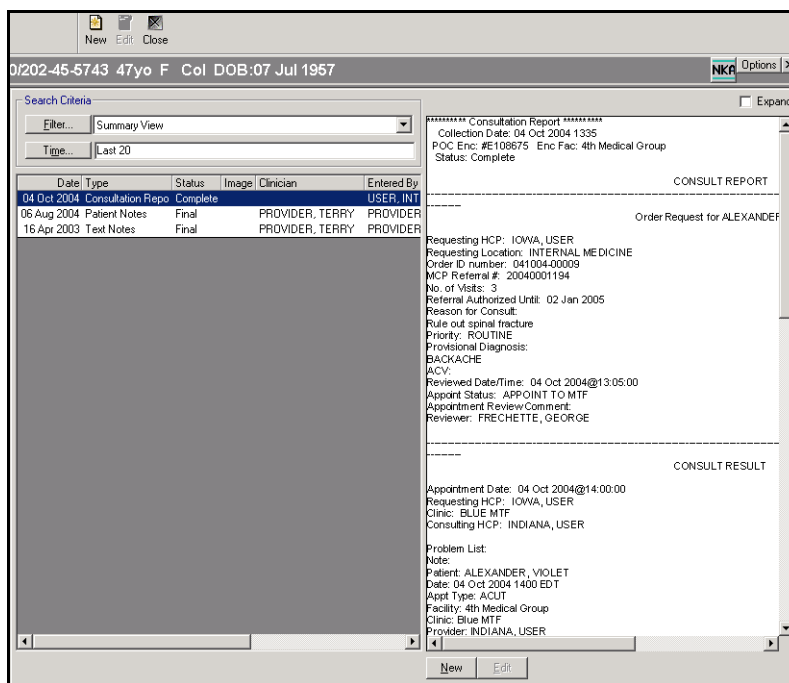


Figure 10-1: Military Clinical Desktop—Clinical Notes Module

10.1.1 In More Depth

The Clinical Notes module allows a CHCS II user to enter, view, and edit notes for a patient that are not associated with an encounter document.

The left side of the Clinical Notes screen displays a list of all the notes entered into the patient's medical record. The notes displayed are based on the Filter and Time search criteria selected by the end user. For each clinical note, the following fields are displayed:

- Date
- Type
- Status
- Image
- Clinician

- Entered By
- Edited By
- Point of Care (POC) Facility

When you highlight a note from the left pane, a preview of the note appears in the right side of the screen. The Expand checkbox in the upper right corner of the screen allows you to review an expanded view of a selected clinical note. Deselecting the checkbox returns the module to the default view.

In addition to creating and saving new notes to a patient's record in the Clinical Notes module, you can also view clinical notes that originate outside of the module. A consult ordered and completed in CHCS is viewable in the CHCS II Clinical Notes module as a Consult Report. Similarly, a consult ordered in CHCS II and completed in CHCS is also viewable in the CHCS II Clinical Notes module.

A consult ordered in CHCS II is sent to CHCS for scheduling. The business process, once the consult crosses over to CHCS, does not change. Depending on how the consult was ordered and completed, completed consults can be viewed as follows:

- Consult ordered in CHCS and completed in CHCS: The consult is viewable in the CHCS II Clinical Notes module and the CHCS Consults module.
- Consult ordered in CHCS and completed in CHCS II: The consult is viewable as an encounter in CHCS II and is written to the CHCS Consult module. The appointment must first be linked to the CHCS II encounter.
- Consult ordered in CHCS II and completed in CHCS: The consult is viewable in the CHCS II Clinical Notes module and the CHCS Consults module.
- Consult ordered in CHCS II and completed in CHCS II: The consult is viewable as an encounter in CHCS II and is written to the CHCS Consults module. The appointment must first be linked to the CHCS II encounter.

10.1.2 Setting the Filter Properties for the Clinical Notes Module

The Filter tab enables the filter name, note type, and associated clinician to be selected.

Follow the steps below to set the filter properties for the Clinical Notes module:

1. Click **Filter** on the Clinical Notes module. The Properties window opens with the Filter tab displayed.

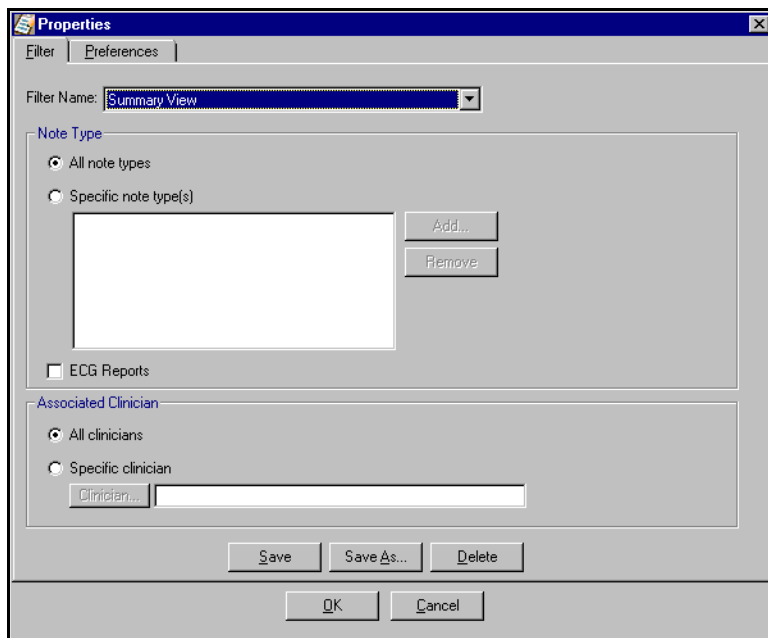


Figure 10–2: Clinical Notes Properties Window (Filter Tab)

2. Select a filter name from the drop-down list.
3. Do one of the following:
 - If you want to view a list of all note types, select **All Note Types**.
 - If you want to view selected note types:
 - a. Select **Specific Note Type(s)**.
 - b. Click **Add**. The Healthcare Data Dictionary Search for Clinical Note Types window opens.

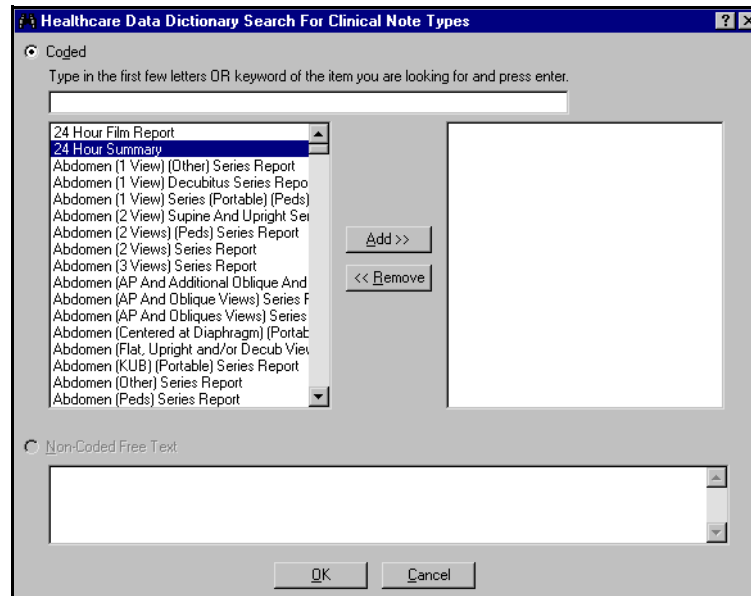


Figure 10–3: Healthcare Data Dictionary Search for Clinical Note Types Window

- c. Select the report(s) you want to add.
 - d. Click **Add**.
 - e. When you have finished adding the selected report(s), click **OK**. The selected reports display in the specific note type(s) area.
4. Do one of the following:
 - If you want to view clinic notes for all clinicians, select **All Clinicians**.
 - If you want to view clinic notes for selected clinicians:
 - a. Select **Specific Clinician**.
 - b. Click **Clinician**. The Clinician Search window opens.

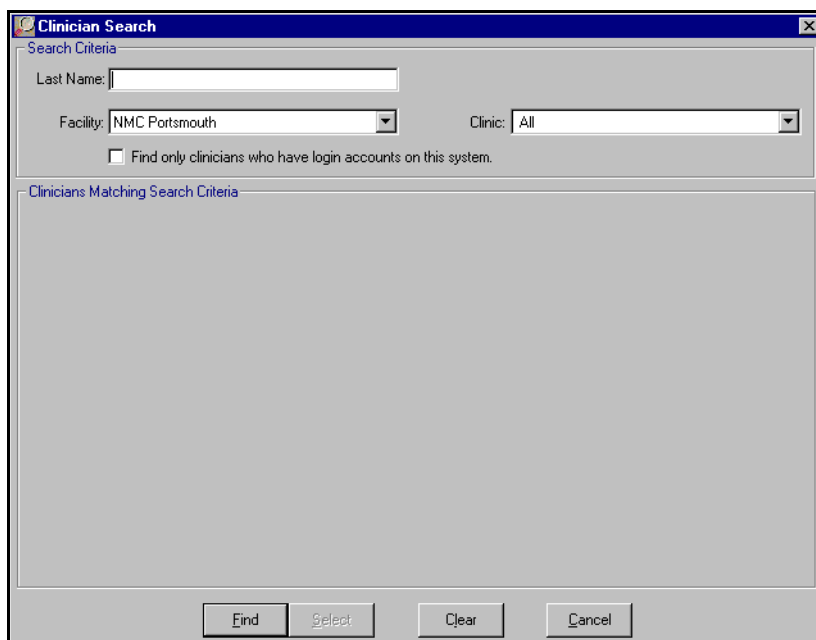


Figure 10–4: Clinician Search Window

- c. Search for the clinician.
5. Click **Save**.

Note: If it is a new filter selection, click **Save As**, enter the name of the new filter and click **Save**.

10.2 Setting Time Preferences for the Clinical Notes Module

The Preferences tab allows you to customize default times to be displayed on the Clinical Notes module.

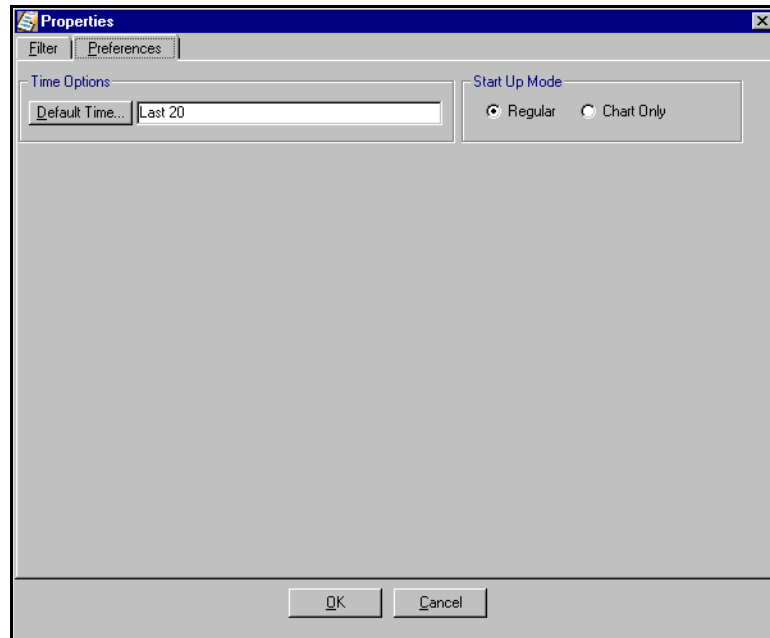


Figure 10-5: Clinical Notes Properties Window (Preference Tab)

Tip:

You can also set time preferences by clicking **Time** on the Clinical Notes module.

Follow the steps below to set time preferences for the Clinical Notes module:

1. Click **Default Time** on the Preferences tab. The Time Search window opens.

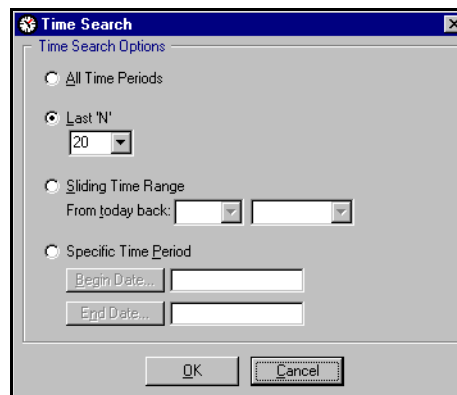


Figure 10-6: Time Search Window

2. Select a time search option.
3. Click **OK**.

Note: The data on the Clinical Notes module is refreshed according to the selected search option. All clinical notes meeting the criteria are listed on the Clinical Notes module. These become your default settings.

10.3 Creating a New Note

Follow the steps below to create a new clinical note for a patient:

1. Click **New** on the Clinical Notes module. The New Clinical Note window opens.

Note: The **Date** field defaults to the current date. If you want to change the date, enter a date or click **Date**. The Calendar window opens and a date can be selected.

Note: The **Clinician** field defaults to the name of the clinician who is currently logged on. If you want to change the clinician, click **Clinician** to search for the clinician you want to add.

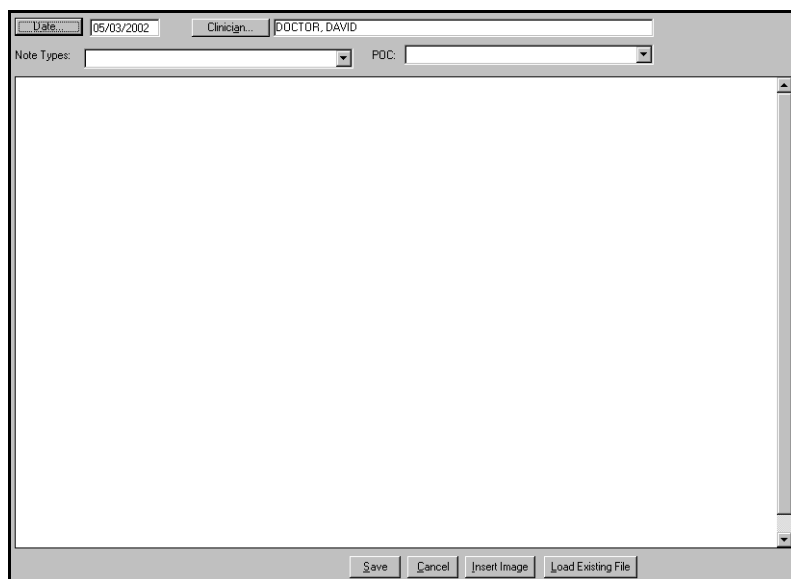


Figure 10-7: New Clinical Note Window

2. Select a Note type from the drop-down list.
3. Select a POC from the drop-down list.
4. In the text field, enter the note.
5. Do one of the following:
 - If you want to insert an image file (i.e., .tif, .bmp, .wmf) in the note:
 - a. Click **Insert Image**.
 - b. Select the file from the Select Destination File window.

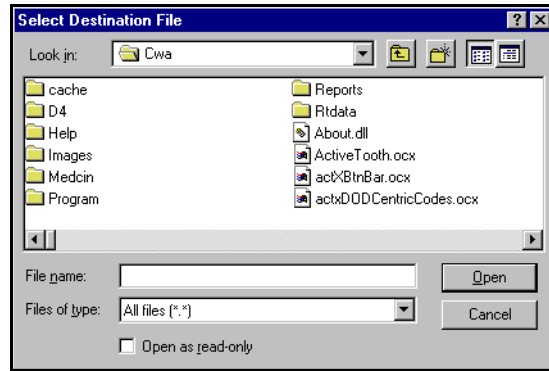


Figure 10–8: Select Destination File Window

- c. Click **Open**. The contents of the file are inserted in the note.

Note: Graphics that are imported must be 500K or less. If the file size is over this amount, the system gives you a message prompt.

- If you want to insert an existing file (e.g., .txt, .rtf, .html) in the note:
 - a. Click **Load Existing File**.
 - b. Select the file from the Select Destination File window.
 - c. Click **Open**. The contents of the file are inserted in the note.
6. Click **Save**. The note displays in the Clinical Notes module.

10.4 Editing a Note

Only the author of the note can modify clinical notes.

Follow the steps below to edit a note:

1. Select the note from the list of notes on the Clinical Notes module. The text of the note displays in right-half of the workspace.
2. Click **Edit** on the Action bar. The Edit window opens.
3. Enter the applicable changes.
4. Click **Save**. The modifications display in the note.

Note: Text notes imported from non-CHCS II systems cannot be edited.

11.0 CONSULT LOG

11.1 Consult Log Overview

The Consult Log module displays all of your consults, both ordered and received. The log displays and continually updates statuses and other information for each consult as it progresses through its lifecycle. In this fashion, the system establishes a tracking log of all actions. The Consult Log can be viewed by Consults Log For Me, Consults Log From Me or Both.

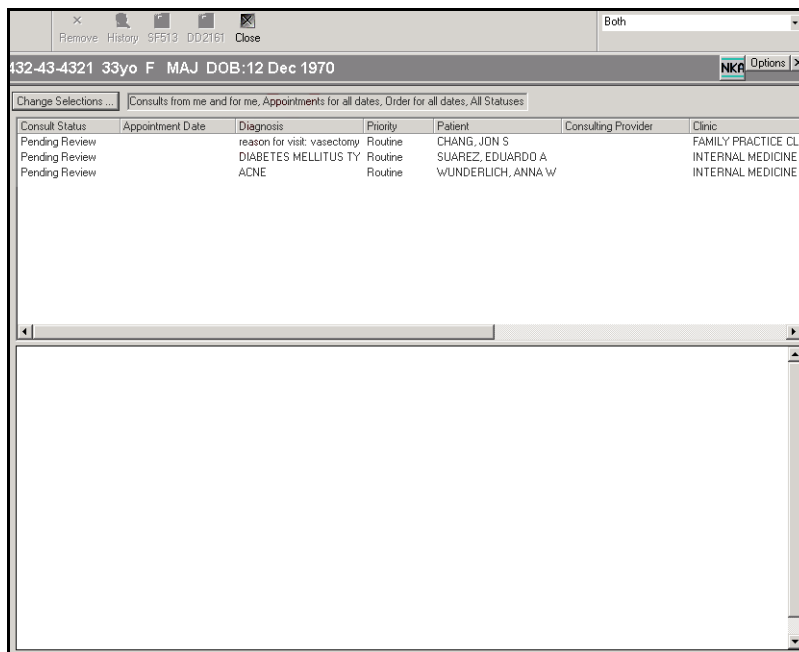


Figure 11-1: Military Clinical Desktop—Consult Log Module

11.1.1 In More Depth

Consults can be sorted (by consult status, appointment date, FMP/SSN, clinical specialty, diagnosis, priority, patient, consulting provider, or PCM) by simply clicking on the perspective column header.

Any actions that have occurred in reference to a consult listed in the Consult Log area of the Consults module can be viewed. The SF 513 and DD 2161 can be printed from the Consult Log module.

A consult ordered in CHCS II is sent to CHCS for scheduling. The business process, once the consult crosses over to CHCS, does not change. Depending on how the consult was ordered and completed, completed consults can be viewed as follows:

- Consult ordered in CHCS and completed in CHCS: The consult is viewable in the CHCS II Clinical Notes module and the CHCS Consults module.

- Consult ordered in CHCS and completed in CHCS II: The consult is viewable as an encounter in CHCS II and is written to the CHCS Consult module. The appointment must first be linked to the CHCS II encounter.
- Consult ordered in CHCS II and completed in CHCS: The consult is viewable in the CHCS II Clinical Notes module and the CHCS Consults module.
- Consult ordered in CHCS II and completed in CHCS II: The consult is viewable as an encounter in CHCS II and is written to the CHCS Consults module. The appointment must first be linked to the CHCS II encounter.

Tip:

Use the scrollbar at the bottom of this area to view the additional Consult Log fields.

11.2 Setting the Consult Log Filter

The Consult Log can be viewed by Consults Log For Me, Consults Log From Me, or both.

Select the filter from the drop-down list in the top, right corner of the Consult Log window to set the Consult Log filter. The consults meeting the criteria appear in the list of consults.

11.3 Setting the Consults Change Selection Criteria

The Consult Log filter allows the user to show consults for the provider, from the provider, or both. The Consult Log Selections Dialog box enables you to apply more advanced filters. Options are available to select a consult status, appointment date, consult order date, patient SSN, PCM, or clinical specialty. Once selections are made, you can make them the default settings or just for the current session.

Follow the steps below to set the consults change selection criteria:

1. Click **Change Selections** on the Consult Log module. The Consult Log Selections window opens.

Figure 11–2: Consult Log Selections Window

2. Select an option in the Consults For area.
3. Select an option in the Consult Status Selection area.
4. Select an appointment date or range.
5. Select a consult order date or range.
6. Select the optional fields, as necessary, you want to display. The optional fields display as additional columns in the Consult Log workspace.
7. Click **OK** to set the selected search criteria. The data on the Consult Log is refreshed according to the search criteria.

11.4 Printing a Consult

You have the capability to print a selected consult on an SF513 form.

Follow the steps below to print a consult:

1. Select the consult you want to print from the Consult Log.
2. Click **SF513** on the Action bar. A Print Preview window opens.

The screenshot shows a 'Print Preview' window with a toolbar at the top (print icon, zoom 83%, page 1 of 1, and a printer icon). The form is titled 'MEDICAL RECORD' and 'CONSULTATION SHEET'. It contains the following sections:

- REQUEST**
 - TO: [blank]
 - FROM: (Requesting physician or activity) DOCTOR, COBI
 - DATE OF REQUEST 27 SEP 2002
- REASON FOR REQUEST (Complaints and findings)**

Allergic Rhinitis not controlled with medication and environmental measures. Please consider for testing and immunotherapy.
- ANTICIPATED LENGTH OF TREATMENT:**
- PROVISIONAL DIAGNOSIS**

ALLERGIC RHINITIS
- DOCTOR'S SIGNATURE** [blank]
- APPROVED*** [blank]
- PLACE OF CONSULTATION**

☐ BEDSIDE ☐ ON CALL
- URGENCY**

Routine
- CONSULTATION REPORT**

Referring Provider: DOCTOR, COBI
Date of Request: 27 Sep 2002
Priority: Routine
Provisional Diagnosis:
ALLERGIC RHINITIS
Reason for Request:
Allergic Rhinitis not controlled with medication and environmental measures. Please consider for testing and immunotherapy.
- SIGNATURE AND TITLE** [blank]
- DATE** [blank]

Figure 11-3: Consult Print Preview Window

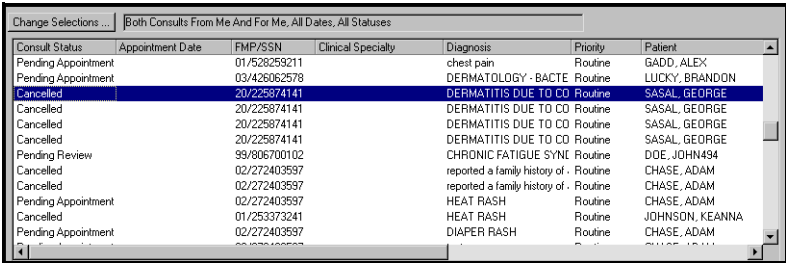
3. Click the print icon. The form is sent to your designated printer.

11.5 Removing a Consult

A consult with a status of Draft or Pending Appointment can be removed from the Consult Log. Consults should be removed from the log when appropriate. This reduces the number of consults to be pulled from the database; therefore, reducing the amount of time it takes to open a consult log module.

Follow the steps below to remove a consult:

- 1. Select the consult from the Consult Log.
- 2. Click **Remove** on the Action bar.



Consult Status	Appointment Date	FMP/SSN	Clinical Specialty	Diagnosis	Priority	Patient
Pending Appointment	01/528259211			chest pain	Routine	GADD, ALEX
Pending Appointment	03/426062578			DERMATOLOGY - BACTE	Routine	LUCKY, BRANDON
Cancelled	20/225874141			DERMATITIS DUE TO CO	Routine	SASAL, GEORGE
Cancelled	20/225874141			DERMATITIS DUE TO CO	Routine	SASAL, GEORGE
Cancelled	20/225874141			DERMATITIS DUE TO CO	Routine	SASAL, GEORGE
Cancelled	20/225874141			DERMATITIS DUE TO CO	Routine	SASAL, GEORGE
Pending Review	99/806700102			CHRONIC FATIGUE SYND	Routine	DOE, JOHN494
Cancelled	02/272403597			reported a family history of .	Routine	CHASE, ADAM
Cancelled	02/272403597			reported a family history of .	Routine	CHASE, ADAM
Pending Appointment	02/272403597			HEAT RASH	Routine	CHASE, ADAM
Cancelled	01/253373241			HEAT RASH	Routine	JOHNSON, KEANNA
Pending Appointment	02/272403597			DIAPER RASH	Routine	CHASE, ADAM

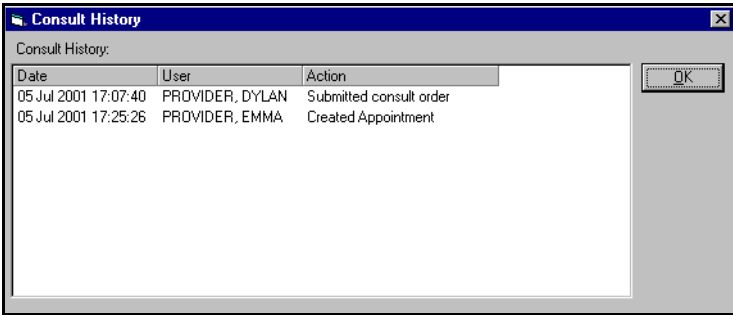
Figure 11-4: Consult Status—Cancelled

11.6 Viewing the History of a Consult

Any actions that have occurred in reference to a consult listed can be viewed.

Follow the steps below to view the history of a consult:

- 1. Select the appropriate consult from the Consult Log list.
- 2. Click **History** on the Action bar. The Consult History window opens.



Date	User	Action
05 Jul 2001 17:07:40	PROVIDER, DYLAN	Submitted consult order
05 Jul 2001 17:25:26	PROVIDER, EMMA	Created Appointment

Figure 11-5: Consult History Window

- 3. Review the information in the Consult History window.
- 4. Click **OK**.

12.0 Co-SIGNS

12.1 Co-signs Overview

The Co-Signs module displays a list of all of the encounters that an individual provider needs to co-sign. The provider can co-sign the appropriate encounters from this module, as well as view encounter details, amend the encounter, and add a narrative.

The screenshot displays the Co-signs Module interface. At the top, there are buttons for 'Append Narrative', 'Amend Encounter', 'Sign Encounter', and 'Close'. Below these is a patient header: '20/202-45-5743 47yo F Col DOB:07 Jul 1957'. A search bar shows 'Encounters Requiring Cosignature by: PROVIDER, TERRY'. A table lists three encounters:

Date	Status	Primary Diagnosis	Clinic	Provider	Enc #
27 Sep 2004 1740	Needs Co-Signature	OTITIS MEDIA RIGHT EAR	CHCSII ITT Clinic	DOCTOR, DAVID	1142
27 Sep 2004 1740	Needs Co-Signature	HYPERLIPIDEMIA	CHCSII ITT Clinic	DOCTOR, DAVID	1143
27 Sep 2004 1704	Needs Co-Signature	ALLERGIC RHINITIS	CHCSII ITT Clinic	DOCTOR, DAVID	1141

Below the table, a dropdown shows 'Signed Encounter Documents: 27 Sep 2004 1740 EDT signed by DOCTOR, DAVID' with '(1 documents found)'. The patient details section includes:

Patient: ALEXANDER, EVELYN Date: 27 Sep 2004 Appt Type: WI
Facility: CHCSII T Clinic Clinic: CHCSII-T Clinic Provider: DOCTOR, DAVID
Co-signer: USER, TEST

AutoCites Refreshed by DOCTOR, DAVID @ 27 Sep 2004 17:52.

Problems
OTITIS MEDIA ACUTE SEROUS

Active Dispensed Medications

Medication Name	Status	Sig	Refills	Last Filled
NEOSYNEPHRINE NASAL 0.25%-NAS 0.125MG/G	Active	1-2 DROPS EACH NOSTRIL Q12HR		Not Recorded

Allergies
Sulfa-Drugs

Vitals
Vitals Written by DOCTOR, DAVID @ 19 Dec 2004 17:52
HR: 90, RR: 16, T: 100.1 F, VWT: 12 kg

SO Note Written by DOCTOR, DAVID @ 19 Dec 2004 17:52
Chief complaint
The Chief Complaint is: Earache.
History of present illness

Figure 12-1: Co-signs Module

12.1.1 In More Depth

The top of the module displays a list of all the encounters requiring co-signatures for the provider logged in. View details of a specific encounter by clicking once on the desired encounter and viewing the details in the bottom half of the workspace.

Clinical team members can set a co-signer when signing an individual encounter or as a default in the AutoCite Properties window.

12.2 Co-Signing an Encounter

All encounters needing co-signatures from the provider currently logged in are listed at the top of the window with the status of Needs Co-Signature.

Follow the steps below to co-sign an encounter:

1. Select the encounter you want to co-sign.
2. Click **Sign Encounter**. The Co-Sign Encounter window opens.

Tip:

Click the **Sensitive** checkbox if you want to mark the appended note as sensitive.

Co-Sign Encounter

Patient: ALEXANDER, EVELYN L	Date: 27 Sep 2004 17:40 EDT	Appt Type: WI
Facility: CHCS II ITT Facility	Clinic: CHCS II ITT Clinic	Provider: DOCTOR, DAVID
Patient Status:	Co-signer: USER, TEST	

Reason for Appointment:

AutoCites Refreshed by DOCTOR, DAVID @ 27 Sep 2004 17:13 EDT

Problems
OTITIS MEDIA ACUTE SEROUS

Active Dispensed Medications

Medication Name	Status	Sig	Refills	Last Filled
NEOSYNEPHRINE NASAL 0.25%-NAS 0.125MG/G	Active	1-2 DROPS EACH NOSTRIL Q12HR		Not Recorded

Allergies
Sulfa-Drugs

Vitals
Vitals Written by DOCTOR, DAVID @ 19 Dec 2004
HR: 90, RR: 16, T: 100.1 °F, WT: 12 kg

SO Note Written by DOCTOR, DAVID @ 19 Dec 2004 17:52 EST

Chief complaint
The Chief Complaint is: Earache.

History of present illness
The Patient is a 2 year 3 month old female who reported a fever of 102.2 axillary. Treated with Motrin and did come down but will return in 6-8 hours.

Enter Your Password: ☐ Auto-Print ☐ Sensitive

Figure 12–2: Co-Sign Encounter Window

3. In the **Enter Your Password** field, enter your password.
4. Click **Sign**.

12.3 Co-Signing an Encounter for Another Provider

Any provider with co-signing privileges can access and subsequently co-sign encounters assigned to another provider.

Follow the steps below to co-sign encounters for another provider:

1. Click **Providers** on the Co-Signs window. The Clinician Search window opens.
2. Search for the clinician. The Co-Signs window displays the list of encounters requiring the selected provider's co-signature.
3. Select the encounter to be co-signed.
4. Click **Sign Encounter**. The Co-Sign Encounter window opens.
5. In the **Enter Your Password** field, enter your password.
6. Click **Sign**.

12.4 Appending a Narrative

The Append Narrative function enables you to attach text or a graphic file to a completed encounter. Graphics that are imported cannot be greater than 500K. The narrative appears at the bottom of the encounter, stamped with the time, date, and author's name. Since the narrative is added after the encounter was signed, the note itself must be signed by the author.

Follow the steps below to append a narrative:

1. Select an encounter.
2. Click **Append Narrative** on the Action bar. The Encounter Note window opens.

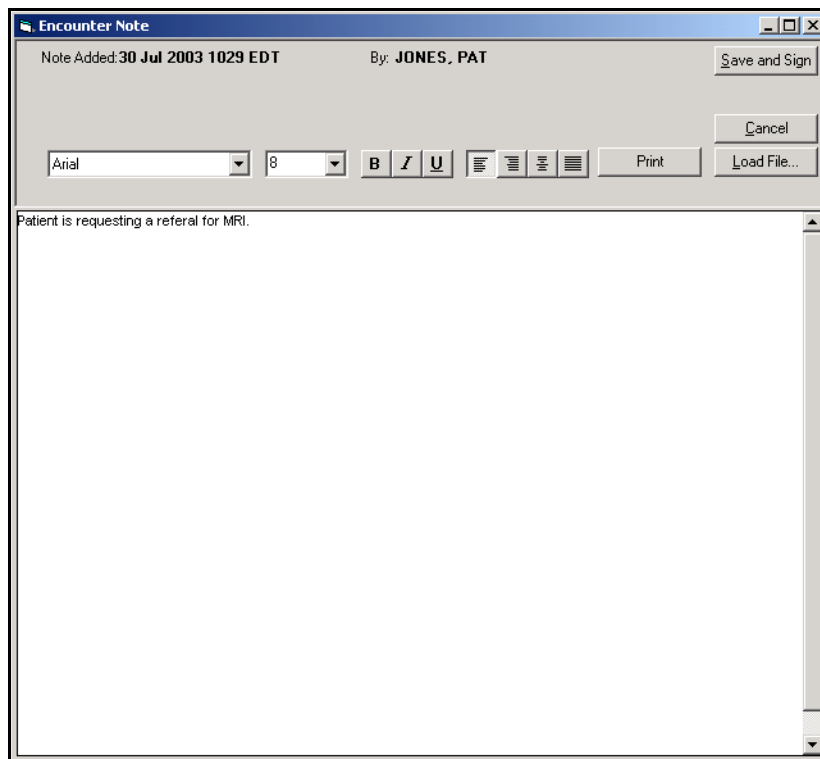


Figure 12-3: Encounter Note Window

3. Enter a note category, if appropriate.
4. Enter a note title, if appropriate.
5. Enter the note in the text box.
6. Do one of the following:
 - If you want to insert a file into the note:
 - a. Click **Load File**. The Select Destination File window opens.

Tip:

Copied text can be pasted directly into the text box.

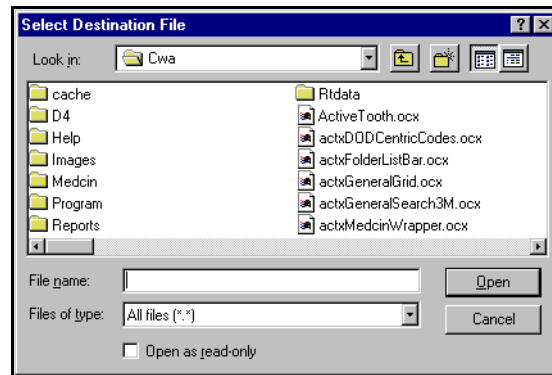


Figure 12-4: Select Destination File Window

- b. Select the file to be added.
- c. Click **Open**. The contents of the file are displayed in the text box.

Note: Graphics that are imported must be 500K or less.

- If you want to print the note for your hardcopy records, click **Print**.
7. Click **Save and Sign**. The Sign Appended Note window opens, so you can review the narrative before signing.

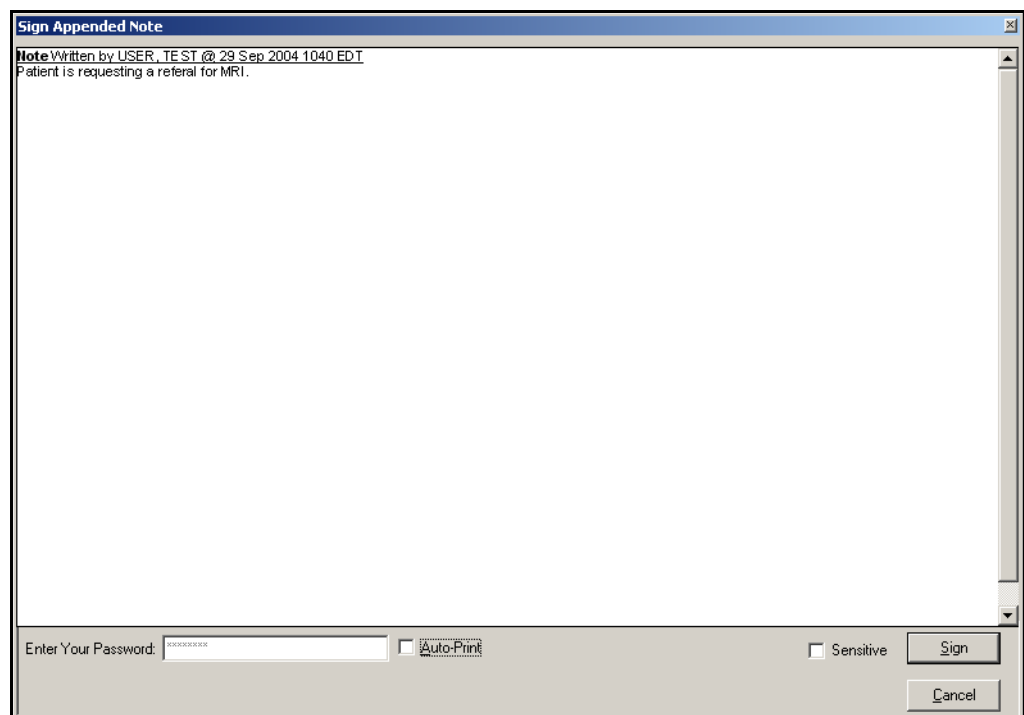


Figure 12-5: Sign Appended Note Window

8. Enter your password and click **Sign**. The narrative appears at the bottom of the encounter summary with the Time, Date, and your name next to the narration.

12.5 Amending an Encounter

Amending an encounter allows original information to be changed by the original provider or the provider's supervisor. Each section that is amended includes the co-signer's name and date stamp. A note is added to the document under Change History at the bottom of the encounter summary stating that the encounter has been amended.

Follow the steps below to amend an encounter:

1. Select the encounter you want to amend.
2. Click **Amend Encounter** on the Action bar. The Patient Encounter window opens for the selected encounter.

Note: The original AutoCited information is moved to the Change History section of the electronic SF600. The AutoCites are refreshed with current information.

The screenshot displays a 'Patient Encounter Summary' window. At the top, it shows the date '27 Sep 2004 1740 EDT', status 'Needs Co-Signature', and MTF 'NMC Portsmouth'. The primary provider is 'DOCTOR, DAVID' and the patient status is 'WI'. The 'Reason for Appointment' is 'AutoCites Refreshed by @ 27 Sep 2004 1713 EDT'. The 'Problems' section lists 'OTITIS MEDIA ACUTE SEROUS'. The 'Active Dispensed Medications' table shows 'NEOSYNEPHRINE NASAL 0.25%-NAS 0.125MG/G' with status 'Active', sig '1-2 DROPS EACH NOSTRIL Q12HR', and 'Refills: Last Filled' 'Not Recorded'. The 'Allergies' section lists 'Sulfa-Drugs'. The 'Vitals' section shows 'Vitals Written by DOCTOR, DAVID @ 27 Sep 2004' with HR: 90, RR: 16, T: 100.1 °F, WT: 12 kg. The 'S/O' section contains a 'SO Note' written by 'DOCTOR, DAVID @ 27 Sep 2004 1740 EDT' detailing the chief complaint of earache, history of present illness, past medical/surgical history, diagnosis of otitis media, personal history, family history, and physical findings.

Medication Name	Status	Sig	Refills	Last Filled
NEOSYNEPHRINE NASAL 0.25%-NAS 0.125MG/G	Active	1-2 DROPS EACH NOSTRIL Q12HR		Not Recorded

Figure 12-6: Patient Encounter Summary

3. Update applicable sections of the encounter.

Note: Any changes replace the original information on the electronic SF600. The original information is moved to the Change History section.

- Once the changes have been made, you must sign the amended encounter. Click **Sign** on the Action bar. The Co-Sign Encounter window opens.

Note: If information is changed in or added to the A/P module, you receive a warning message suggesting that you return to the Disposition module to verify the E&M code.

Co-Sign Encounter

Patient: ALEXANDER, EVELYN L	Date: 27 Sep 2004 17:40 EDT	Appt Type: WI
Facility: CHCSII ITT Facility	Clinic: CHCSII ITT Clinic	Provider: DOCTOR, DAVID
Patient Status:		Co-signer: PROVIDER, TERRY

Reason for Appointment:

AutoCites Refreshed by DOCTOR, DAVID @ 27 Sep 2004 17:13 EDT

Problems
OTITIS MEDIA ACUTE SEROUS

Active Dispensed Medications

Medication Name	Status	Sig	Refills	Last Filled
NEOSYNEPHRINE NASAL 0.25%-NAS 0.125MG/G	Active	1-2 DROPS EACH NOSTRIL Q12HR		Not Recorded

Allergies
Sulfa-Drugs

Vitals
Vitals Written by DOCTOR, DAVID @ 19 Dec 2004
HR: 90, RR: 16, T: 100.1 °F, WT: 12 kg

SO Note Written by DOCTOR, DAVID @ 19 Dec 2004 17:52 EST

Chief complaint
The Chief Complaint is: Earache.

History of present illness
The Patient is a 2 year 3 month old female who reported a fever of 102.2 axillary. Treated with Motrin and did come down but will return in 6-8 hours.

Enter Your Password: ☐ Auto-Print ☐ Sensitive

Figure 12-7: Co-Sign Encounter Window

- In the **Enter Your Password** field, enter your password.
- Click **Sign** to sign the encounter. The Change History section of the encounter is documented with the amendments and you are returned to the Appointments module.

13.0 DEMOGRAPHICS

13.1 Demographics Overview

The Demographics module displays the patient's demographic information. Certain demographic information can be updated. The patient's home address, city, state, zip code, country, home and work phone, e-mail address, religion, comments, and the location of the records can be modified in the Edit mode. Third-Party insurance information, Special Work Status, and Required Fields information can be viewed and modified. Information on a patient's Primary Care Manager (PCM) and the Defense Enrollment Eligibility Reporting System (DEERS) eligibility cannot be modified.

The screenshot displays the 'Demographics Module' interface. At the top, a status bar shows '20/202-45-5743 47yo F Col DOB:07 Jul 1957' and a toolbar with 'Edit', 'Save', 'Cancel', 'Ins. Form', and 'Close'. Below this, the 'Patient Information' section contains fields for Name (ALEXANDER, VIOLET), SSN (202-45-5743), Birth Date (07 Jul 1957), Age (47yo), Sex (F), Marital Status (Married), Race (Black), Patient Category (M11 USMC ACTIVE DUTY), FMP (20), Enrollment Facility (4th Medical Group), and Facility Description (4th Medical Group). To the right, there are input fields for Home Address (789 MAIN ST), City (ANYWHERE), State/Country (NY), Zip (12345), Home Phone (123-333-3333), Work Phone (123-333-4444), and Religion. Below these are fields for Comments, Command Interest, and Command Security. A table at the bottom left shows 'Prim. Care Mgr.', 'Spec Wk Status', 'DEERS Eligibility' (Eligible), and 'Required Fields' (SADR Data Complete). The 'Sponsor Information' section shows Name (ALEXANDER, VIOLET), SSN (202-45-5743), UIC (SM1CFH76), Rank/Grade (COLONEL), and Service (MARINES). The 'Insurance Information' section has a table with columns for Insurance Company Name, Address, Policy Number, Group Name, Group Number, and Insurance Co. Phone. At the bottom, there are buttons for 'Enter Changes to Patient Insurance Information' and 'Completed'.

Figure 13-1: Military Clinical Desktop—Demographics Module

Note: Any edits to the demographic information in CHCS II are overwritten by CHCS and DEERS updates.

13.1.1 In More Depth

The Demographics module contains pertinent information about the patient that is pulled from CHCS. Although certain demographic elements can be edited in the Demographics module, any edits to the demographic information are overwritten by the information held in the Defense Eligibility Enrollment Reporting System (DEERS).

Most of the demographic information can be viewed and edited outside of an encounter. A current encounter must be open in order to modify the patient's Special Work Status or enter new third-party insurance information.

13.2 Editing Demographic Information

Certain demographic information can be updated in the Patient Demographics module. These fields include a patient's religion, home address, home and work phone, comments, and the location of the records. The rest of the information on the left is read-only and can only be updated in CHCS.

Follow the steps below to edit demographic information:

1. In the Appointments List, select a patient name.
2. In the Folder list, click **Demographics**. The Demographics module opens.
3. On the Action bar, click **Edit**.

Figure 13–2: Demographics Module

4. Update the necessary fields in the Demographics module.
 - **Home Address, Phone Numbers, and E-Mail:** Enter necessary changes in the applicable fields. Tab or use the mouse to move to the next field.

Note: The **Country** field is limited to 12 characters including spaces.

- **Religion:** Use the drop-down list to select the desired religion.
- **Comments:** In the Comments text box, enter information applicable to the Demographics module.
- **Records Maintained At:** Use the drop-down list to select the location of the patient's paper records. Use the scroll bar to view all options.

5. On the Action bar, click **Save**. Once the information is saved, it is visible upon returning to the Demographics module, unless it has been overwritten by CHCS or DEERS.

Tip:
Right-click in any of the test fields to access the editing functions (cut, copy, paste).

13.3 Viewing Primary Care Provider Information

Follow the steps below to view primary care provider information:

1. Click **Prim. Care Mgr**. The Primary Care Manager Information window opens containing read only information.

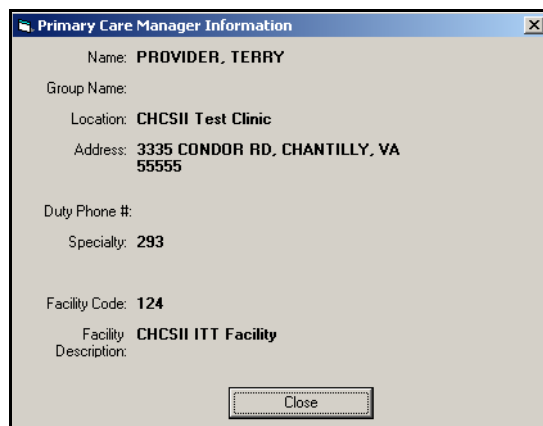


Figure 13-3: Primary Care Manager Information Window

2. Click **Close** to return to the Demographics module.

13.4 Modifying Special Work Status

An encounter must be open in order to modify Special Work Status. If an encounter is not open, the **Special Work Status** button is disabled. When an encounter is open, the button is enabled and Special Work Status information can also be modified. This information can be modified in the Demographics module, the Screening module, and the Disposition module.

Follow the steps below to modify special work status:

1. Click **Spec Wrk Status**. The Special Work Status window opens.

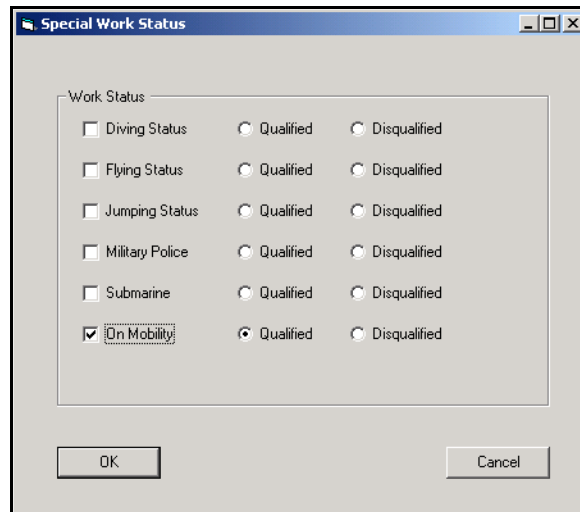


Figure 13-4: Special Work Status

2. Select the checkbox next to each applicable work status.
3. Select **Qualified** or **Disqualified** for the associated work status.
4. Click **OK**. You are returned to the Demographics module and the icon associated with the selected work status appears on the Patient ID Bar.

13.5 Viewing DEERS Eligibility

Follow the steps below to view DEERS Eligibility:

1. Click **DEERS Eligibility**. The DEERS Eligibility window opens. This is a read-only window.

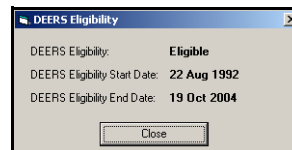


Figure 13-5: DEERS Eligibility Window

13.6 Updating Required Fields

If the fields that are required for each patient have not been completed, SADR Data Incomplete appears in red beside the button.

Follow the steps below to update required fields:

1. Click **Required Fields**. The Required Fields window opens.

The screenshot shows a window titled "Required Fields" with a close button (X) in the top right corner. The window contains the following fields and values:

Patient Date of Birth:	23 Mar 1964
Family Member Prefix (FMP):	20
Military Grade/Rank:	MAJOR
Patient Social Security Number:	803-64-0323
Sponsor Social Security Number:	803-64-0323
Alternate Care Value (ACV):	[Drop-down menu]

At the bottom of the window are two buttons: "Save Changes" and "Close".

Figure 13–6: Required Fields Window

2. The following fields must be updated if there are any changes or errors:
 - **Family Member Prefix (FMP):** Enter the FMP.
 - **Military Grade/Rank:** Enter the correct grade or rank.
 - **Alternative Care Value (ACV):** Use the drop-down list to select the additional insurance plan.
3. Click **Save Changes** to update the record and open the Demographics module. Once the SADR information is complete, SADR Data Complete appears beside the **Required Fields** button.

13.7 Printing the Insurance Form

A copy of the patient's insurance information can be printed for verification or to note changes. The form can also be printed from the Appointments and Demographics modules. This form defaults to the current date and includes demographic information with space to update the address, phone numbers, current insurance information, and questions for the patient to answer regarding any changes.

Follow the steps below to print the Insurance Form:

1. Click **Ins. Form** on the Action bar to print an insurance form for a patient. The Print Preview window opens.
2. Click the printer icon on the Preview window to print the form. The form is sent to your designated printer.

13.8 Entering New Third-Party Insurance Information

An encounter must be open in order to enter third-party insurance information. If an encounter is not open, No Encounter Open displays next to the disabled **Enter Changes to Patient Insurance Information** button. When an encounter is open, the button is enabled and insurance information can be documented.

Follow the steps below to enter new third-party insurance information:

1. Click **Enter Changes to Patient Insurance Information**. The Patient Insurance Information window opens.

Patient Insurance Information

Does patient have health insurance other than Medicare or Champus?
☐ Yes ☐ No

Has any health insurance information changed since last visit?
☐ Yes ☐ No

Insurance Company Name:

Insurance Company Telephone:

Insurance Company Address:

Insurance ID Number:

Group Name:

Group Number:

Subscriber's Name:

Patient's Relationship to Subscriber:

Effective Date... 30 Jul 2003

Expiration Date... 30 Jul 2003

Person Capturing Information:

Information Source:

Comments:

Figure 13–7: Patient Insurance Information Window

2. Click either **Yes** or **No** in response to the first two questions.
3. Enter the applicable information into the following fields:
 - **Insurance Company Name:** Enter the name of the insurance company.
 - **Insurance Company Telephone:** Enter the company's phone number.
 - **Insurance Company Address:** Enter the company's address.
 - **Insurance ID Number:** Enter the policy number.
 - **Group Name:** Enter the name of the group with which the subscriber is associated.
 - **Group Number:** Enter the group number.
 - **Subscriber's Name:** Enter the name of the policy holder.
 - **Patient's Relationship to Subscriber:** Enter the relationship of the patient to the person subscribed to the insurance policy.
 - **Effective Date/Expiration Date:** Select these buttons to access the Calendar window in order to select the effective date and the expiration date for the insurance policy.

Note: The system defaults to the current date.

- **Person Capturing Information:** Enter the name of the person filling out this form.
- **Information Source:** Enter the source of the insurance information.
- **Comments:** Enter any comments for this entry.

4. Click **Save**.

14.0 DISPOSITION

14.1 Disposition Overview

The Disposition module is used to document the disposition and E&M codes of an encounter. In this module, you can record the discharge status of the patient from the clinic, follow-up information, and the patient's understanding of the assessment and plan. In addition, the E&M codes are calculated and selected.

The screenshot shows the 'Disposition' module interface. At the top, there's a patient header: '202-45-5743 47yo F Col DOB:07 Jul 1957'. Below this, the 'Disposition' section has a dropdown for 'Released w/o Limitations'. The 'Encounter Context' section includes checkboxes for 'Related to Injury/Accident?' and 'Patient Pregnant'. The 'Billing and Admin' section shows 'Billing Chief Complaint: 455.9 - UPPER RESPIRATORY INFECTION', 'Appt Class: Outpatient', and 'Meets Outpt Visit Criteria (Workload)? Yes'. The 'Follow Up' section has checkboxes for 'PRN' and 'With PCM', and a 'Comments' text area. The 'Discussed' section includes checkboxes for 'All Items Discussed', 'Diagnosis', 'Medication(s)/Treatment(s)', 'Potential Side Effects', and 'Alternatives', along with an 'indicated understanding' checkbox and a 'Comments...' button. The 'Time Factor' section has checkboxes for '>50% time spent counseling or coordinating care' and 'Total face to face or floor time in minutes: 30'. The bottom section, 'Calculated', includes a 'Patient Status' dropdown (Existing Patient), 'Exam Type' (General Multi-System), and a 'Reset' button. Below these are dropdowns for 'Setting' (Outpatient) and 'Service Type' (Outpatient Visit). A table displays calculated E&M codes for various categories: HPI, RDS, PFSH, Overall History, Exam, Dx/Mgt Options, Complexity of Data, Overall MDM, Problem Risk, Tests Risk, Mgt Risk, and Overall Risk. The 'Default Calculation' is set to '99213 - Estab Outpatient Expanded H&P - Low Complexity Decisions'. A checkbox for 'With User overrides:' is also present.

HPI	RDS	PFSH	Overall History	Exam	Dx/Mgt Options	Complexity of Data	Overall MDM	Problem Risk	Tests Risk	Mgt Risk	Overall Risk
1 2	1 2 3	1 2	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4

Figure 14-1: Military Clinical Desktop—Disposition Module

14.1.1 In More Depth

The Disposition module is typically the last module in the patient encounter process. It collects information from the entire process and begins the coding and billing processes. Options found on the Disposition module are dependent on the appointment type, appointment classification and whether or not the appointment is a count or no-count visit.

The bottom part of the module houses the E&M Calculator. CHCS II calculates a suggested code for the encounter based on the structured terms and documentation entered in the S/O and A/P modules and the appointment type, patient status, service type and whether or not the encounter was a counseling visit. Calculation is completed

using the 1997 Documentation Guidelines from the Centers for Medicare and Medicaid Services (CMS).

Note: The CMS organization was previously known as the Healthcare Financing Administration (HCFA).

14.2 Completing the Disposition

14.2.1 Assigning a Disposition

Follow the steps below to assign a disposition:

1. Select the appropriate disposition from the Disposition drop-down list. You can only select one option. Depending on whether the patient's appointment classification is outpatient or inpatient, different options are available.

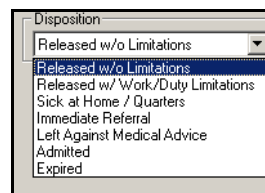


Figure 14–2: Disposition Drop-down List Outpatient

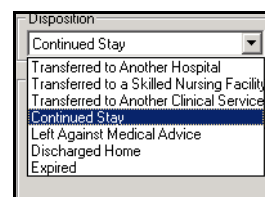


Figure 14–3: Disposition Drop-down List Inpatient

Based on your selection, additional fields become active and require input:

- If **Released with Work/Duty Limitations** is selected, click **Profile** to document the limitation. The Temporary Profile window opens.

Figure 14–4: Temp Profile Window

- **Start Date and End Date:** Select the appropriate time frame by clicking the drop-down arrow and selecting the dates from the calendar.
- **Diagnosis:** Select the diagnosis causing the limitation from the drop-down list.
- **Limitation:** In the Limitation free text field, describe the patient's limitations.
- Click **OK**. The profile is documented and is displayed on the electronic SF600.

Note: You are still required to complete a paper profile form to be sent to the patient's supervisor.

- If **Sick at Home/Quarters** is selected, specify the correct time period (24, 48, or 72 hours).
- If **Immediate Referral** is selected, enter the provider's name to whom the patient is being referred.
- If **Left Against Medical Advice** is selected, click **Comments** to document detailed information on the patient's actions.
- If **Admitted** is selected, click **Comments** to document detailed information concerning the admission.
- If **Expired** is selected, click **Comments** to document additional information.

14.2.2 Completing the Encounter Context Fields

The Encounter Context fields display in other areas of the application and simply need to be reviewed here. The injury/accident designation typically occurs when creating the appointment in CHCS II or in the A/P module when documenting an e-code diagnosis.

- **Related to Injury/Accident?:** If the appointment is related to an injury or an accident, select this checkbox. The Date and Related Cause Code window appears.

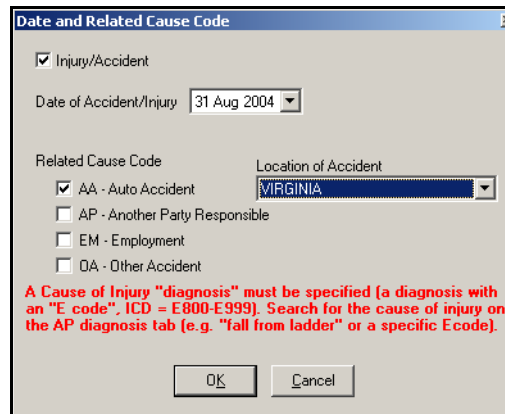


Figure 14-5: Date and Related Cause Code Window

- Complete all fields and click **OK**. Notice the checkbox indicating that the date and Related Cause Code have been entered.

Note: An encounter marked as related to an injury or accident is required to contain an E-code as one of the diagnoses. A notification appears when you attempt to close the A/P module or sign the encounter if the encounter is marked as related to an injury or accident and no E-code (diagnosis) was selected.

Tip:

If the pregnancy and/or injury/accident information was added in the Screening module, then you can review the information here. If the information was not added in the Screening module, you can record the information now.

Pregnancy information, for female patients, is gathered in the Screening module but changes can be made in the Disposition module as well.

The fields associated with Female Only Data display for female patients 12 years of age or older.

Follow the steps below to add female only data:

1. Click the **Patient Pregnant** checkbox to open the Pregnancy Related window.
2. In the Female Only Data area, select the checkboxes to all the fields that apply.
 - **Pregnant**

Note: If the patient is pregnant, the Last Menstrual Period and the Estimated DOB are required fields.

- **Post Menopause**
- **Post Hysterectomy**
- **Last Menstrual Period:** Select this checkbox to activate the date drop-down field. Select the appropriate date.

- **Estimated DOB:** Select this checkbox to activate the date drop-down field. Select the appropriate date.

Note: On the electronic SF600, the estimated DOB is written as the EDC (Estimated Date of Confinement).

- **Birth Control Method:** Click the checkbox next to the appropriate birth control method.
- **G, P, A, LC:** Click the drop-down list and select the appropriate value.

3. Click **OK**.

14.2.3 Filling out the Billing and Admin Fields

These fields are completed based on information gathered in the Appointments and A/P modules.

Follow the steps below to change the Billing and Admin information:

1. To change the Billing Chief Complaint, click the drop-down arrow to select another diagnosis that was entered in the A/P module.
 - Use the ellipsis to search for a diagnosis that was not documented in the A/P module. The Select Diagnosis window opens.
 - Check the Clinic and Favorites tab for the appropriate diagnosis. If the diagnosis is not on one of these tabs, click the **Search** tab.
 - Enter the diagnosis and click **Search**.
 - Select the diagnosis from the list and click **OK**. The selected diagnosis fills in the appropriate field.
2. To change the Appointment Classification, click the drop-down arrow to select from the options. The options available in the drop-down list will vary, based on the patient's appointment classification in CHCS. If the classification is Inpatient, this field cannot be changed.
3. Click **Admin Options** to document additional information and work status. The Administrative Options window opens.

The screenshot shows a window titled "Administrative Options". It contains two main sections: "Admin Options" and "Work Status".

Admin Options:

- ☒ Consultation requested
- ☐ Referred to another provider
- ☐ Convalescent leave
- ☐ Medical board
- ☐ Medical hold

Work Status:

Work Status	Qualified	Disqualified
<input type="checkbox"/> Diving Status	<input type="radio"/> Qualified	<input type="radio"/> Disqualified
<input type="checkbox"/> Flying Status	<input type="radio"/> Qualified	<input type="radio"/> Disqualified
<input type="checkbox"/> Jumping Status	<input type="radio"/> Qualified	<input type="radio"/> Disqualified
<input type="checkbox"/> Military Police	<input type="radio"/> Qualified	<input type="radio"/> Disqualified
<input type="checkbox"/> Submarine	<input type="radio"/> Qualified	<input type="radio"/> Disqualified
<input type="checkbox"/> On Mobility	<input type="radio"/> Qualified	<input type="radio"/> Disqualified

At the bottom, there are fields for "DMIS: 0090", "PATCAT: M11 USMC ACTIVE DUTY", "MEPRS: BHAA", and "ACV:". There are also "OK" and "Cancel" buttons.

Figure 14-6: Administrative Options Window

Tip:

For a more detailed description on Count vs. Non-Count, click the **question mark** icon next to the drop-down list.

- In the Admin Options area, select items that apply.
 - Click the checkbox next to the applicable work status(es) and select either **Qualified** or **Disqualified**.
 - Click **OK**.
4. **Meets Visit Criteria:** This field determines whether this encounter is a count or no-count visit. Yes, is count; No is no-count. If No is selected, the available E&M codes are no-count codes.

14.2.4 Documenting Follow-up Information

This area allows you to document the instructions given to the patient about further treatment or appointments. This information is written to the electronic SF600. Data entered here concerning follow-up appointments does not trigger the scheduling of an appointment. This must be done using the current process.

Follow the steps below to document follow-up information:

1. Click the checkbox to denote a follow-up appointment as needed (PRN) or with the primary care manager (PCM).
2. Complete the time and location fields, as appropriate.
 - **When:** Select this option to enter a timeframe for the follow-up appointment.
 - Click the **ellipsis** button. The Follow-up in window opens.

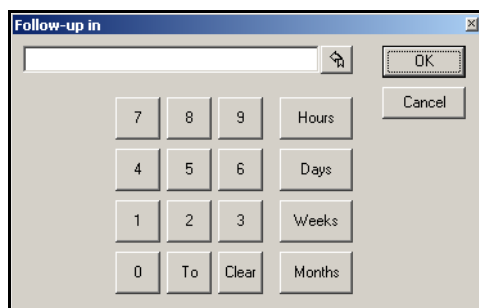


Figure 14-7: Follow-up in Window

- Click the appropriate numeric value and then the timeframe. Click **OK**. Your selection populates the When field.
- **For Tx:** The Follow-Up for Treatment window allows you to enter a specified period of time and number of visits regarding treatments associated with the current encounter.
- Click the **ellipsis** button. The Follow-up for Treatment window opens.



Figure 14-8: Follow-up for treatment Window

- Select the applicable abbreviation (e.g., QIW = 4 times a week) and the timeframe required for the treatment.
 - Select the time period and click **OK**. Your selection populates the For Tx field.
 - **In Clinic:** Use the drop-down arrow and select the clinic in which the patient needs to follow up.
3. Enter comments, as necessary.

14.2.5 Document a Patient's Understanding of the A/P

This area allows you to document which items were discussed with the patient and that the patient indicated understanding of each item.

Follow the steps below to document understanding:

1. Select items that were discussed with the patient.

Tip:

The default setting can be set via the AutoCite Properties window off the Encounter Summary module (electronic SF600).

2. If all items were discussed and the patient understood each item, click the check-box next to **All Items Discussed**. This marks each item as well as document the patient's understanding.
3. If the discussion occurred with someone other than the patient, use the drop-down list to select the appropriate party.
4. Enter comments, as necessary.

14.2.6 Selecting an E&M Code

The E&M calculator provides a suggested E&M code. It takes into account each structured term documented in the S/O note, the documented assessment and plan items, and the settings of key filters to determine the suggested E&M code.

The 1997 HCFA Documentation Guidelines are the basis for E&M coding. There are twelve parameters used to calculate the code. The CHCS II Disposition module pulls data for each of these parameters from the structured data entered in the note. The most important parameters are Overall History, Exam, and Medical Decision Making (MDM).

Because the calculator uses structured terms to determine the code, if a provider uses a lot of free text, the calculator is not as accurate. It is important, from a coding perspective, then, to build and use templates that are made up of the structured terms.

In addition to the structured terms, the calculator relies on three filters to produce an accurate code: Time Factor, Patient Status, and Service Type.

Follow the steps below to select the appropriate E&M code:

1. Change the following filters, as appropriate.
 - **Time Factor:** Select this option for visits in which more than 50% of the time was spent counseling or coordinating care. In this case, the E&M code is based on the amount of time spent with the patient. Adjust the Face-to-Face Floor time, as appropriate. The time field defaults to the scheduled appointment duration.
 - **Patient Status:** The E&M code is partially based on the type of patient being seen; a new patient or an existing patient. 'New' means that this is the first time this patient has been seen in the clinic. 'Existing' means a chart exists for that patient at that clinic. These two different options affect the coding for an encounter because a new patient is calculated differently.

Note: Patient Status defaults to New Patient if the patient has not been seen in the same Clinic/Specialty within the past three (3) years.

- **Setting:** Use the drop-down list to select the appropriate setting for this encounter.
- **Service Type:** The most common selection is **Outpatient Visit**. Use the **Preventive Evaluation or Management Type** for routine physicals and well-

baby checks. With these types of appointments, the E&M code is based on the patient's age.

Note: The options available in the Setting and Service type drop-down lists are based on the appointment type and appointment classification.

- **Exam Type:** The default exam type is General Multi-System. Use the drop-down list to select a more specific exam type.
2. Review and accept the suggested E&M code. If you wish to override the code, go to step 3.

Note: The level of each of the twelve parameters is listed under the headings, highlighted in blue.

3. The suggested E&M code can be changed from the Calculated tab. Click the desired numerical button underneath the parameters to indicate what the level should be. As you change the levels, an additional E&M code is displayed beneath the suggested code.

Note: The user overrides are highlighted in red.

Figure 14–9: Calculated Tab - User Override Selected

4. As you change the levels, an additional E&M code is displayed beneath the suggested code. Click the **With User overrides** radio button to select the new E&M code.

14.2.6.1 To manually select the E&M Code:

1. Click the **Selection** tab.

E&M Codes	
E&M	Evaluation & Management
99211	OFFICE /OUTPT VISIT EST PT
99212	OFFICE /OUTPT VISIT EST PT
99213	OFFICE /OUTPT VISIT EST PT
99214	OFFICE /OUTPT VISIT EST PT
99215	OFFICE /OUTPT VISIT EST PT

Figure 14–10: Selection Tab

2. Select an **E&M Category** from the drop-down list.
3. Select an E&M code from the results list for the associated E&M category. The **E&M code** and **E&M help** fields automatically populate with detailed code information.

Note: The available options are determined by the patient's status and the appointment type.

14.2.6.2 To add Additional E&M Codes or E&M Modifiers:

E&M code modifiers allow you to document altered services or procedures performed during the patient encounter (i.e., an evaluation and management service with a procedure on the same day).

E&M code modifiers most frequently used include:

- **-21 Prolonged Evaluation and Management Services:** Used only with the highest level of service within a given category or subcategory of E&M services. This modifier is appended to the E&M service(s) when the service(s) provided is prolonged or otherwise greater than usually required for the highest level of E&M service with a given category.
- **-24 Unrelated Evaluation and Management Service By the Same Physician During a Postoperative Period:** Used when a physician who has provided a surgical service related to one problem, now provides an E&M service unrelated to the problem requiring the surgery, during the period of follow-up care for the surgery. The modifier -24 is also used to describe a visit to treat an underlying condition following surgery.
- **-25 Significant, Separate Identifiable Evaluation and Management Service By the Same Physician on the Day of a Procedure:** The physician may need to indicate that on the day a procedure or other service identified by a CPT-4 code was performed, the patient's condition required a significant, separately identifiable E&M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed.
- **-57 Decision For Surgery:** Used to indicate that this encounter was the encounter that resulted in the initial decision to perform surgery. While some carriers will not pay E&M visits by the surgeon within a certain time period, this modifier

should indicate that this visit should be considered as a separate charge from the surgery due to the nature of the initial work-up. For Medicare, this modifier pertains to encounters the day before, or the day of, a major surgery (90 day postoperative period).

Follow the steps below to add a modifier or additional E&M code:

1. Click the **Additional E&M Coding** tab.

Note: The Calculated and Additional E&M Coding tabs are only enabled if the Workload is set to **Count**.

Tip:
Tool Tips are available when you hover your mouse over an individual modifier.

2. Select additional coding modifiers from the drop-down lists. Up to three modifiers can be associated with one E&M code. Select or uncheck the associated diagnoses, as appropriate.
3. Add additional E&M codes, as appropriate.
 - Click the ellipsis button next to E&M Code 2 to open the Selection window.
 - Select an **E&M Category** from the drop-down list.
 - Select an E&M code from the results list for the associated E&M category. The **E&M code** and **E&M help** fields automatically populate with detailed code information
4. Click **Save** on the Action bar.

15.0 FLOWSHEETS

15.1 Flowsheets Overview

The purpose of the Flowsheets module is to display multiple data items such as lab values, medication profile (drug, dosage, and frequency), and vital signs in a chronological descending format over a period of time without having to open an encounter. You must select a patient to access this module.

Date	1/20/2003 1154	1/20/2003 1151	1/20/2003 1147	1/20/2003 1142	1/13/2003 1038	12/20/2002
BP	130/70	120/67		125/74	125/70	120/6
HR				75	65	
RR						
T		98.6				
HT	76	71				
WT						
PeakFlow						
Tobacco	No		Yes	Yes		
Alcohol	No		Yes	Yes		
Entered By	DOCTOR, GARY	DOCTOR, GARY	DOCTOR, GARY	DOCTOR, GARY	DOCTOR, GARY	DOCTOR, GARY
Encounter	89582	89582	89582	89582	88570	8503
Pain Scale						
BMI						
BSA						

Figure 15–1: Military Clinical Desktop—Flowsheets Module

15.2 Viewing Flowsheets

When you access the Flowsheet module, the Vital Signs Flowsheet is displayed by default.

Follow the steps below to view a flowsheet:

1. Select **Lab Results** or **Medications** in the drop-down filter in the upper, right corner to view additional flowsheets. A flowsheet is created with all past data.
2. The Flowsheet can be configured to show desired information by clicking in the checkbox next to the desired information shown at the right of the Flowsheet module.

Note: Items in the Configuration Panel pertain only to the selected flowsheet.

15.3 Printing Flowsheets

Follow the steps below to print flowsheets:

1. Select the flowsheet you want to print:
 - Vital Signs
 - Lab Results
 - Medications
2. Do one of the following:
 - If you want to print the entire flowsheet, click **Print Entire Flowsheet**. The worksheet is sent to your local printer.
 - If you want to print a portion of the flowsheet:
 - a. Select the portion of the flowsheet you want to print.
 - b. Click **Print Flowsheet Portion**.

Note: The **Print Flowsheet Portion** button is inactive until the columns are selected.

16.0 HEALTH HISTORY

16.1 Health History Overview

The Health History module displays historical patient data from various modules in one window. The window can be customized to show different modules containing the patient's information.

The screenshot shows a software window titled "20/202-45-5743 47yo F Col DOB:07 Jul 1957" with a "Close" button and an "Options" button. The window is divided into several sections:

- Problems:** A table listing medical conditions with columns for Problem, Comment, and Chronicity. The listed problems are METRORRHAGIA, IRON DEFICIENCY ANEMIA, and ESSENTIAL HYPERTENSION BENIGN, all marked as Chronic.
- Allergies:** A section indicating "No Known Allergies".
- Lab Results (Last 10):** A table with columns for Date Collected, Report Type, Report, Status, and Results. It shows three recent results for CBC W/D# and Urinalysis, with one result for WBC noted as "WBC => 7.0 => .".
- Radiology Summary:** A table with columns for Event Date, Procedure, Ordering Provider, and MTF. It lists three recent imaging reports: Pelvis AP (Erect) Series Report, Right Ankle Series Report, and L-Spine (2 Views) Series Report, all ordered by FRECHETTE, GEORGE.
- Meds:** A section with tabs for Inpt. and Outpt. It includes a table with columns for Last Filled, Medication Name, Sig, and Status. It lists three medications: FERROUS SULFATE-PO 325MG TAB, HCTZ (ESIDREX/ORETIC)-PO 25MG TAB, and AMLODIPINE (NORVASC) 5MG-PO 5MG TAB, all with a status of Active.

Figure 16-1: Military Clinical Desktop—Health History Module

16.1.1 In More Depth

When opening the Health History module for the first time, you must select the modules to display in the Health History module and design the window layout. The Health History module is useful to the clinical team members because it provides a quick “snapshot” of the patient's medical history. Reviewing a patient's medical history is an important step in the patient evaluation process because information about allergies, lab results, problems, etc. can affect the current evaluation.

16.2 Customizing the Health History Module

Follow the steps below to customize the Health History module:

1. Click **Options** on the Health History module. The Design Summary window opens.

Note: If opening Health History for the first time, you will receive a message stating that no modules have been selected. Click **OK** and proceed with step 1.

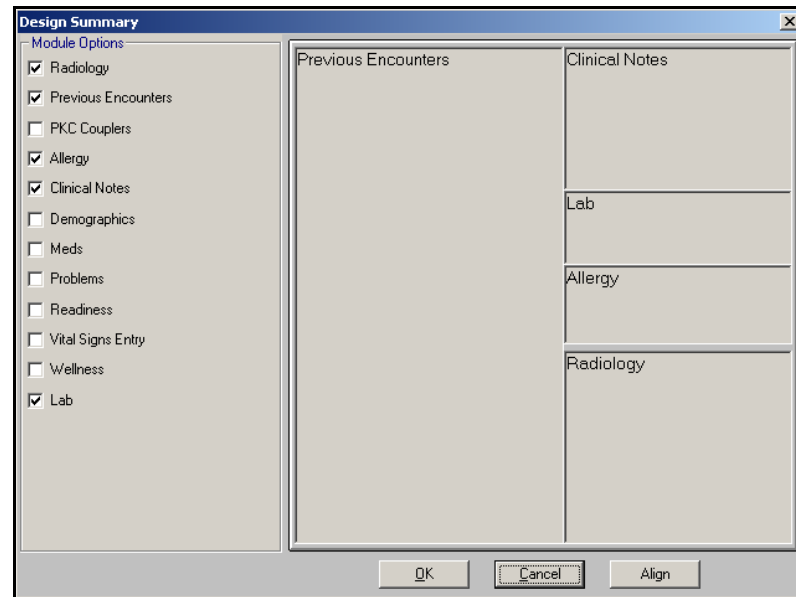


Figure 16-2: Design Summary Window

2. Select **Module Options** for which you want patient information to display in the Health History module. Each module selected is placed in the middle of the design screen. Click and drag the module to position it within the design screen.
3. Click **Align** to allow the system to place the selected modules.
4. Click **OK**.

16.3 Viewing Historical Modules

Modules selected for display on the Health History module are easily accessible. Historical modules can be accessed and viewed by double-clicking the desired module in the Health History module. The selected module opens. To return to the Health History module, close the current module.

17.0 IMMUNIZATION ADMIN

17.1 Immunizations Admin Overview

The Immunization Admin module is used to administer and manage vaccines, providers, reports, user groups, and refrigeration temperature logs. It is also used to document multiple vaccine entries for selected patients. The Immunizations Admin module contains two tabs: Admin and Multiple Entry. The Immunizations Admin module can be accessed without loading a patient's medical record.

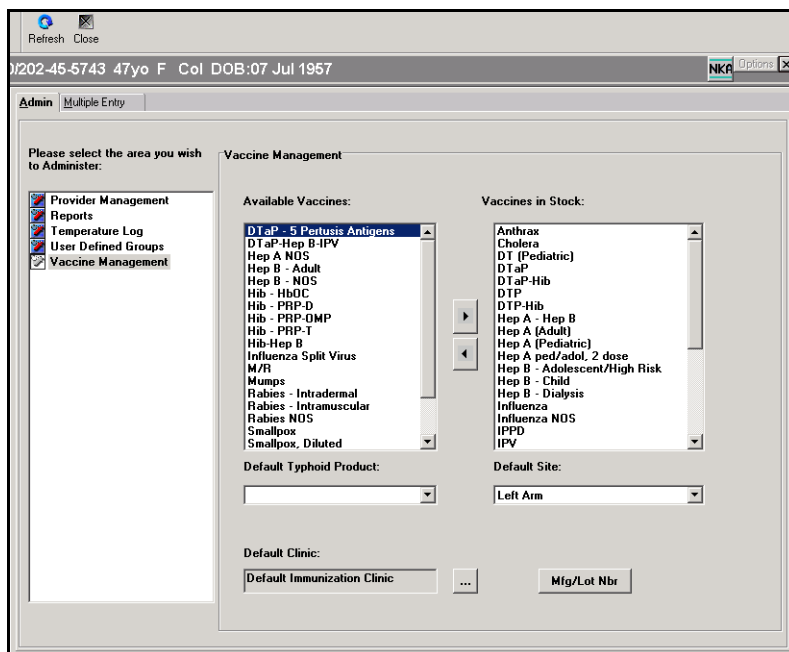


Figure 17-1: Military Clinical Desktop—Immunizations Admin Module

17.1.1 In More Depth

The Immunizations Admin tab is used to setup the Immunizations Clinic at an MTF. Before immunizations can be administered to a patient, the vaccines must be placed in stock in the Immunizations Clinic using CHCS II.

The recommended workflow for deploying CHCS II to a brand new Immunizations Clinic is as follows:

- Evaluate existing CHCS business processes
- Establish business processes for CHCS II
- Establish CHCS II user roles for clinic team members
- Inventory vaccines

- Immunization Admin updates Vaccine Management area in CHCS II (Vaccine in Stock) with Vaccine Inventory for default clinic or multiple clinics
- Immunization Admin sets up clinic defaults on applicable workstations
- Develop a default encounter template for use by the Immunizations Clinic
- Train Immunizations Clinic team members

A user with immunization administrator privileges is able to create or select a default clinic. The Default Immunization Clinic in the Vaccine Management area is a pre-loaded clinic. When CHCS II is deployed to a brand new Immunizations Clinic, the Vaccines in Stock lists all of the vaccines known by CHCS II. When a new clinic is created, the immunization administrator has to select the vaccines in stock from the list of Available Vaccines. Available Vaccines are standard throughout the DoD system. CHCS II allows you to enter specific vaccine elements such as vaccine name, series, manufacturer, lot number, dosage, site, route, etc. for each vaccine schedule.

New vaccines are added to the list of available vaccines in CHCS II per approval by a federal government panel. Following the approval process, the vaccine can be added to the local MTF, but only by an end user with Enterprise-level access privileges. End users at the local MTFs can not change vaccine schedules per new guidelines issued by the Centers for Disease Control and Prevention.

If CHCS II is being deployed to an existing Immunizations Clinic, the Vaccines in Stock may have already been populated by an immunization administrator. This information is stored in a database table.

The Immunization Admin can set up clinic defaults on applicable workstations. Setting the clinic defaults establishes the origin of vaccine information when vaccines are administered to patients.

The Immunizations Admin Multiple Entry tab is used to document multiple vaccine entries for patients selected from a Unit/UIC. You can access the Rapid Data Entry option to quickly enter vaccine information using a bar code reader.

17.2 Adding User-Defined Groups

A user-defined group is a required set of immunizations for specified patient groups. The groups can be created per clinic, patient, or deployment requirements. When a Service member is assigned to a user-defined group, the required immunizations automatically adjust to include the immunizations that are a part of the group.

CHCS II allows you to create new user-defined groups. Service-specific groups defined by the DoD are preloaded in the application.

Follow the steps below to add user-defined groups:

1. Click **User Defined Groups** on the Admin tab. The User Defined Groups area displays.

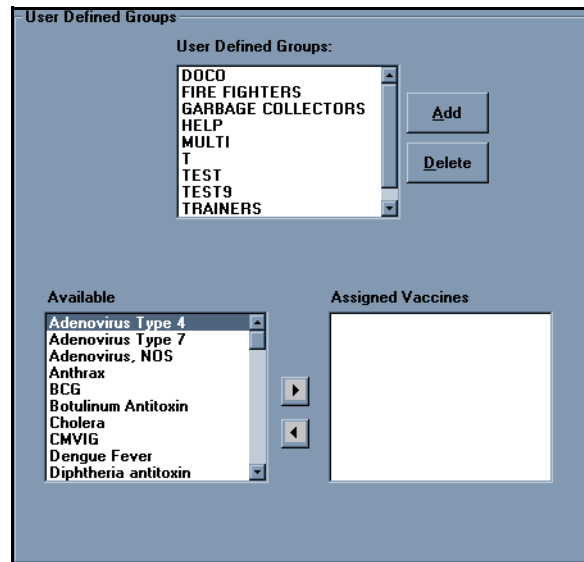


Figure 17-2: Immunizations Admin—User Defined Groups

2. Click **Add**. The Add User Defined Group window opens.

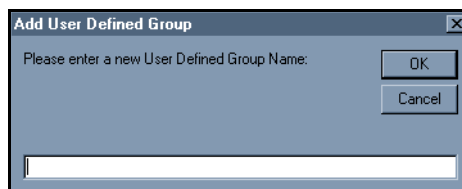


Figure 17-3: Add User Defined Group Window

3. Enter the name of the user group you want to add.
4. Click **OK**.

17.3 Adding a Refrigerator

Follow the steps below to add a refrigerator:

1. Click **Temperature Log** on the Admin tab. The Refrigerator Temperature Log area displays.

Refrigerator Temperature Log

Refrigerator	Date	Time	Temp	Clinic

Refrigerator ID:

Admin Name:
Temperature:
☐ F ☐ C

Admin Rank:
Date:

Admin ID:
Time:
☐ A ☐ M ☐ P ☐ 2

☐ All Refrigerators
☐ Selected Only

Figure 17-4: Immunizations Admin—Temperature Log

2. Select the clinic for which you are adding the refrigerator.
3. Click **Add/Mod**. The Add/Modify a Refrigerator window opens.

Default Immunization Clinic

Ref-ID	Min Deg	Max Deg	Serial-Number
GE1	25 F	45 F	1234565
GE2	25 F	47 F	0990-0999
GE3	20 F	40 F	345678912

Refrigerator ID:

Alias Name

Serial Number

Valid Temperature Range

Low

High

☒ F ☐ C

Delete Clear Input Add Exit

Figure 17-5: Add/Modify a Refrigerator Window

- Complete the following fields:
 - Alias Name:** Enter the name of the refrigerator (such as Maytag, GE, Westinghouse).
 - Serial Number:** Enter the refrigerator's serial number for identification and tracking purposes.
 - Low Temperature:** Enter the refrigerator's low temperature. This is the minimum temperature at which the refrigerator should ever operate.
 - High Temperature:** Enter the refrigerator's high temperature. This is the maximum temperature at which the refrigerator should ever operate.
- Click **Add**.

17.4 Adding a Vaccine for Multiple Entry

Follow the steps below to add a vaccine for Multiple Entry:

1. Click **Add** on the Multiple Entry tab. The Vaccines in Stock window opens.

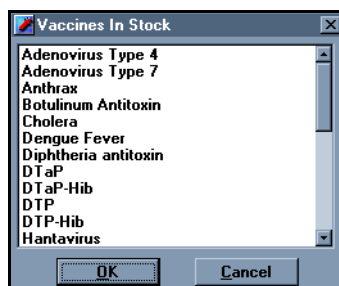


Figure 17-6: Vaccines in Stock Window

2. Select a vaccine from the list of available vaccines.
3. Click **OK**. The vaccine is added to the list of vaccines on the Multiple Entry tab.

Note: Select a vaccine and click **Delete** to delete the vaccine from the multiple entry list.

Note: In order to edit vaccine information from the multiple entry list, click in the field you want to edit. Click the **down arrow** to open the applicable window and modify the information.

Figure 17-7: Immunizations Admin—Multiple Entry Tab

- Clicking the **Rapid Data Entry** button enables you to enter vaccines by bar code reader.

17.5 Assigning Vaccines to User Defined Groups

Follow the steps below to assign vaccines to User Defined Groups:

- Click **User Defined Groups** on the Admin tab. The User Defined Groups area displays.

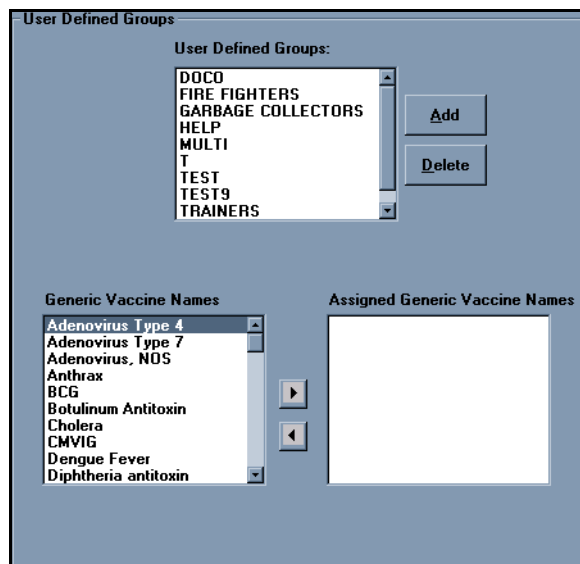


Figure 17–8: Immunizations Admin—User Defined Groups

- Select a **User Defined Group**.
- Select a vaccine from the Generic Vaccine Names list.
- Click the **Right Arrow** button to move the vaccine to the Assigned Generic Vaccine Names list.

17.6 Deleting Providers from Administering Immunizations

A provider can be deleted from administering immunizations; however, the provider is added back to the eligible provider list when he/she administers a vaccine.

Follow the steps below to delete a provider from administering immunizations:

- Click **Provider Management** on the Admin tab. The Provider Management area displays.

Imm ProviderID	Last Name	First Name	MI
13306108	OCHS	STEVEN	E
13303303	PRATT	LAURA	
13359516	PROVIDER	DAVID	
13359530	PROVIDER	DYLAN	
13359517	PROVIDER	EMMA	
13365870	PROVIDER	FIFTY	
13365863	PROVIDER	FIFTY	
13365868	PROVIDER	FIFTY	F
13365861	PROVIDER	FORTY	
13365859	PROVIDER	FORTY	S
13365849	PROVIDER	FORTY	T
13376945	PROVIDER	SEVENTY	F
13376944	PROVIDER	SEVENTY	F

Delete

Figure 17-9: Immunizations Admin—Provider Management

2. Select a provider from the list in the Provider Management area.
3. Click **Delete**.

17.7 Entering Multiple Vaccines for a Patient

Follow the steps below to enter multiple vaccines for a patient:

1. Select an **Immunization Provider** from the drop-down list on the Multiple Entry tab.

The screenshot shows the 'Multiple Entry' tab in the Immunizations Admin interface. At the top, there is a table with columns: Vaccine, Mfg. Code, Lot. Nbr, Vacc. Dose, Route, Site, and VIS. Below this table are 'Add' and 'Delete' buttons. A 'Find Patient' field is present, followed by an 'Immunization Date' field set to '16 Aug 2004'. Below the date field is an 'Immunization Provider' dropdown menu set to 'WELLNESS NURSE'. A 'Rapid Data Entry' button is located below the provider dropdown. The main section is a 'UIC/Unit Patient List' table with columns: Name, SSN, and Sel. Below this table are 'Select All', 'Deselect All', and 'Log Selected' buttons. At the bottom, there is a 'UIC/Unit' dropdown menu set to '0372 TRAINING SQ (LEQJF62N)'. A status bar at the bottom indicates 'Record: 1 of 37'.

Vaccine	Mfg. Code	Lot. Nbr	Vacc. Dose	Route	Site	VIS
Anthrax	BA	AAA	.5 mL	SC	Left Arm	No
Hep A (Adult)	BA	hl777	.5 mL	IM	Left Arm	No

Name	SSN	Sel
BFYXTS GQFPJ R	785283367	No
BFYXTS GWFID R	778222470	No
BFYXTS GWFJTS R	778124433	No
BNQNFRRX HFWD Q	850373027	No
FSLJQTYTF FSYMTSD X	771269435	No
FSLJQTYTF HMWNCYNSJ	849392790	No
FSLJQTYTF OTMS X OW	779723900	No
FWHMJW FQGNXTS I	774124603	No
FWHMJW HNSID W	787767167	No
FWHMJW OFRJJ F	788627461	No
FWHMJW OFRJJ W	029396955	No
GFPJW QFWWD I	959649909	No
GFPJW RFYJMJB I	351456765	No

Figure 17-10: Immunizations Admin—Multiple Entry Tab

Note: The **Immunization Date** field defaults to the current date. Enter the applicable date in the field if the current date is not the correct date.

2. Select the patient for whom you want to enter multiple vaccines.
3. Click the **Select** field for the associated patient and click the **down arrow** to select the patient.

Note: Click **Select All** if you want to enter the same multiple vaccines for every patient in the list.

4. Click **Log Selected**.

17.8 Logging Refrigerator Temperatures

Follow the steps below to log refrigerator temperatures:

1. Click **Temperature Log** on the Admin tab. The Refrigerator Temperature Log area displays.

Figure 17-11: Immunizations Admin—Temperature Log

2. Select a clinic from the drop-down list.
3. Select a refrigerator from the drop-down list.
4. Complete the following fields:
 - **Temperature:** Enter the temperature of the refrigerator you are logging in the system. You can enter a temperature in degrees Fahrenheit or Celsius.
 - **Date:** Enter the date you are logging the temperature in dd mm yyyy format.
 - **Time:** Enter the time you are logging the temperature. You can enter the time in AM, PM, or Military.
5. Click **Add**.

Note: Click the **All Refrigerators** radio button, then click **Show All Entries** to view all logged refrigerator temperatures for the selected clinic.

17.9 Modifying Refrigerator Temperature Logs

Follow the steps below to modify refrigerator temperature logs:

1. Click **Temperature Log** on the Admin tab. The Refrigerator Temperature Log area displays.
2. Select a clinic from the drop-down list.
3. Select a refrigerator from the drop-down list.

4. Select the **Selected Only** radio button.

Note: Click the **All Refrigerators** radio button, then click **Show All Entries** to view all logged refrigerator temperatures for the selected clinic.

5. Click **Show All Entries**.
6. Update the following fields, as necessary:
 - Temperature
 - Date
 - Time
7. Click **Modify**.

17.10 Modifying a Refrigerator

Follow the steps below to modify a refrigerator:

1. Click **Temperature Log** on the Admin tab. The Refrigerator Temperature Log area displays.
2. Select a clinic from the drop-down list.
3. Click **Add/Mod**. The Add/Modify a Refrigerator window opens.

The screenshot shows the 'Refrigerator Temperature Log' window with the 'Add/Mod' tab selected. At the top, there are two dropdown menus: 'Clinic' (set to 'Default Immunization Clinic') and 'Refrigerator' (set to 'Big Bertha'). Below these is a table with columns: Refrigerator, Date, Time, Temp, and Clinic. The table is currently empty. Below the table, there is a section for 'Refrigerator ID: Big Bertha' with input fields for 'Admin Name' (PROVIDER, EMMA), 'Admin Rank' (Civilian), 'Admin ID' (13359517), 'Temperature' (with F/C radio buttons), 'Date', and 'Time'. At the bottom, there are 'Delete', 'Clear Input', and 'Add' buttons. Below the buttons are two radio buttons: 'All Refrigerators' and 'Selected Only' (which is selected). A 'Show All Entries' button is also present.

Figure 17-12: Immunizations Admin—Add/Modify a Refrigerator

4. Double-click the refrigerator you want to modify.
5. Update the following fields, as necessary:
 - **Alias Name:** Enter the name of the refrigerator (such as Maytag, GE, Westinghouse).
 - **Serial Number:** Enter the refrigerator's serial number for identification and tracking purposes.
 - **Low Temperature:** Enter the refrigerator's low temperature. This is the minimum temperature at which the refrigerator should ever operate.

- **High Temperature:** Enter the refrigerator's high temperature. This is the maximum temperature at which the refrigerator should ever operate.

6. Click **Modify**.

Note: If you want to delete the refrigerator, click **Delete** and click **Yes** at the confirmation prompt.

17.11 Printing Immunization Reports

Follow the steps below to print immunization reports:

1. Click **Reports** on the Admin tab. The Report Options area displays.

Figure 17–13: Immunizations Admin—Reports

2. Select a report from the drop-down list.

Note: Information for the selected report displays in the Report area. The information displayed depends on what report you select.

3. Click **Print**.
4. Select a print range on the Print window.
5. Click **OK**.

17.12 Selecting a Default Vaccination Clinic

Follow the steps below to select a default vaccination clinic:

1. Click **Vaccine Management** on the Admin tab. The Vaccine Management area displays.

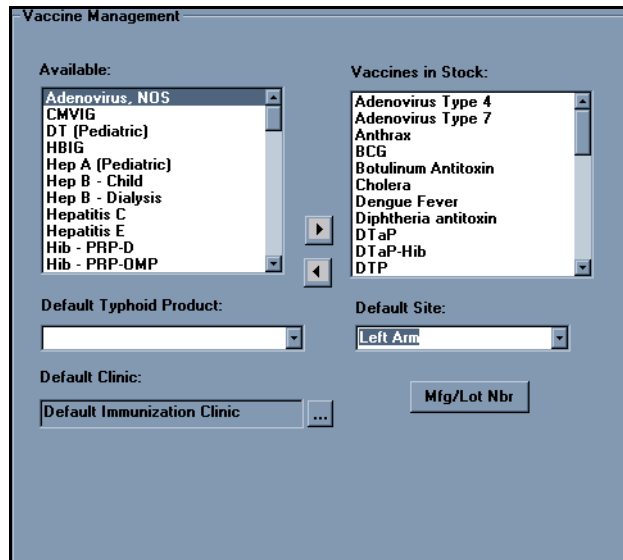



Figure 17–14: Immunizations Admin— Vaccine Management

2. Click the **Ellipsis** button  next to the **Default Clinic** field. The Clinic List Edit window opens.

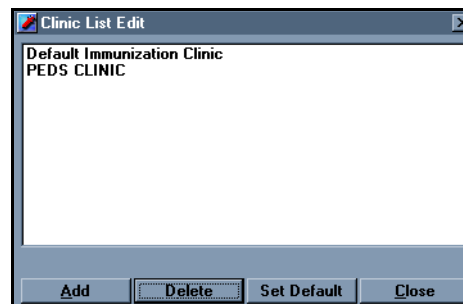



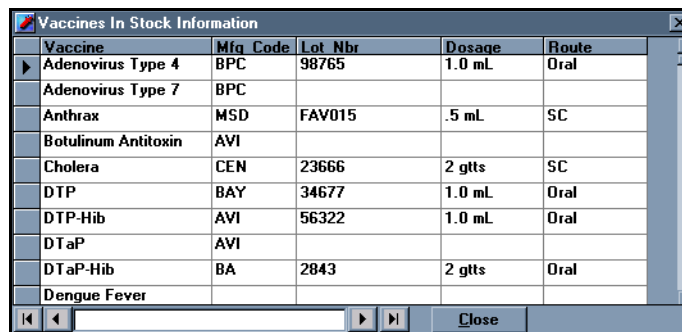
Figure 17–15: Clinic List Edit Window

3. Select the clinic from the list.

Note: If the clinic you want to select is not listed, click **Add**. In the text field, enter the clinic name and press **Enter** on your computer keyboard.

4. Click **Set Default**. You are returned to the Vaccine Management area.
5. Do one of the following:
 - If you want to associate stocked vaccines to the default clinic:

- Select a vaccine from the list of available vaccines.
- Click the **Right Arrow**  button. The vaccine is moved to the Vaccines in Stock list.
- If you want to set the default typhoid product, select the typhoid product from the drop-down list.
- If you want to set the default body area where the vaccine is given, select the site from the drop-down list.
- If you want to view the manufacturer and lot number information for the vaccines in stock:
 - Click **Mfg/Lot Nbr**. The Vaccines in Stock Information window opens.



Vaccine	Mfg Code	Lot Nbr	Dosage	Route
Adenovirus Type 4	BPC	98765	1.0 mL	Oral
Adenovirus Type 7	BPC			
Anthrax	MSD	FAV015	.5 mL	SC
Botulinum Antitoxin	AVI			
Cholera	CEN	23666	2 gtt	SC
DTP	BAY	34677	1.0 mL	Oral
DTP-Hib	AVI	56322	1.0 mL	Oral
DTaP	AVI			
DTaP-Hib	BA	2843	2 gtt	Oral
Dengue Fever				

Figure 17-16: Vaccines In Stock Information Window

- Click **Close** to return to the Admin tab.

17.13 Viewing the Vaccine Lot Number List

Follow the steps below to view the Vaccine Lot Number List:

1. Click **Reports** on the Admin tab. The Reports area displays.

Report Options

Select Report:

TB Skin Test Positive List

Lot Numbers

Start Date:

End Date:

☐ Report will use dates:

1 Jan 1980

31 Dec 2020

☐ Include page Break

☒ Do Not Include SSAN

☒ Group On Unit

☐ Group On Office

☐ Summnd

Preview

Print

Export

Figure 17-17: Immunizations Admin—Reports

2. Click **Lot Numbers**. The Vaccine Lot Number List window opens.

Vaccine Lot Number List

Vaccine: Anthrax

Refresh

Manufacturer	Lot Nbr	Nbr
Bayer	FAV016	4
Bioport	FAV047	56
Bioport	TRANSCRIBED	2
Greer	TRANSCRIBED	1
Merck	12345	1
Merck	FAV015	5
Other	hsdgsdgsdfgsdfg	4

Record: 1 of 7

Print

Details

Close

Figure 17-18: Vaccine Lot Number List Window

3. Select a vaccine from the drop-down list. Manufacturer information displays for each manufacturer associated with the selected vaccine.
4. Select a manufacturer.
5. Click **Details**. All patients associated with the vaccine distributed by the selected manufacturer display.

Note: Click **Details** to edit the immunization history for the selected patient.

Note: You can also click the drop-down arrow to view detailed information for manufacturers and patients.

18.0 LABORATORY

18.1 Laboratory Overview

The Lab module is designed to display the results of laboratory tests. Results are viewed, not ordered, from this module. Lab results are pulled from CHCS and an alert is triggered when new results are received. The Lab module is defaulted to display ten lab results. The default value can be changed, but this may impact your wait time and system performance.

Type	Date Collected	Date Ordered	Date Resulted	Report	Ordering Provider	MTF	Site/Specimen	Sample
Standard Lab	27 Sep 2004 1058	27 Sep 2004 1035	27 Sep 2004 1113	CBC w/Diff	FRECHETTE, GEORGE	4th Medical Group	BLOOD	BL000
Standard Lab	27 Sep 2004 1058	27 Sep 2004 1035	27 Sep 2004 1107	Urinalysis	FRECHETTE, GEORGE	4th Medical Group	URINE	RND/UR

Test / Result Name	Site/Specimen	Collection Date / Result Values
CBC w/Diff	Site/Specimen	27 Sep 2004 1058
WBC	BLOOD	7.0
RBC	BLOOD	3.90 (L)
Hgb	BLOOD	10.1 (L)
Hct	BLOOD	33.0 (L)
MCV	BLOOD	79.0 (L)
MCH	BLOOD	27.0 (L)
MCHC	BLOOD	32.0 (L)
RDW-CV	BLOOD	12.0
Grans	BLOOD	5.0 (L)
Lymphs	BLOOD	8.0 (L)
Mono	BLOOD	8.0
Eos	BLOOD	5.5
Baso	BLOOD	8.0 (H)
Plt	BLOOD	200
MPV	BLOOD	11.0 (H)

Figure 18-1: Military Clinical Desktop—Laboratory Module

18.1.1 In More Depth

During site activation or when an appointment is first made in CHCS II for a particular patient, 36 months worth of patient lab results are pulled from CHCS and are stored in the CDR. These results are accessible through the Lab module.

Lab tests are ordered through CHCS II in the A/P module. The order is sent back to CHCS for processing. When the test is complete and the results are entered into CHCS, they are sent to the CDR and an alert is triggered in CHCS II for the ordering provider. All lab results, then, are reviewed in the Lab module.

18.2 Creating a Search Filter in the Lab Module

The results listed in the Lab module can be filtered. You can create a filter to sort lab results for which you are interested in.

Follow the steps below to create a filter for viewing lab results:

1. Click **Options** on the Lab module. The Lab Results Properties window opens.
2. Click the Filter tab.

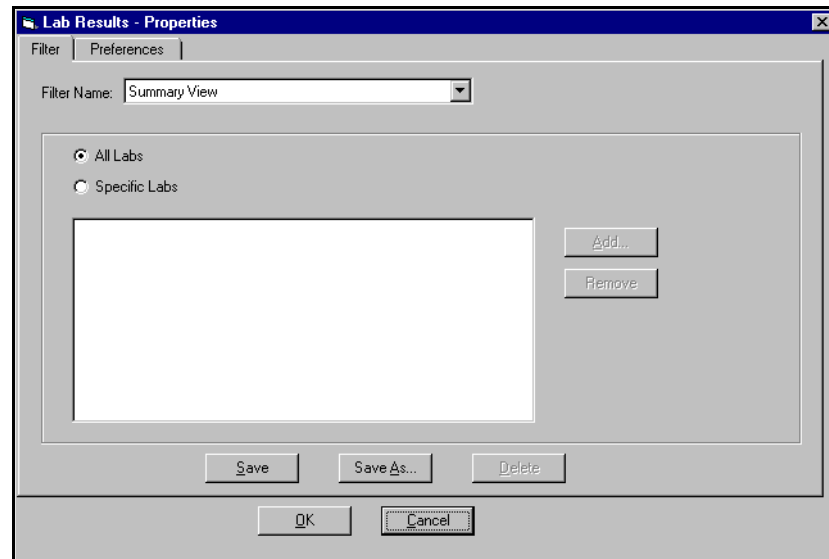


Figure 18-2: Lab Results—Properties Window—Filter Tab

3. Select the applicable radio button for the lab results you want to view.
 - If **All Labs** is selected, all of the listed lab results are displayed.
 - If **Specific Labs** is selected, click **Add** to open the Add Lab Type window to add specific lab results.
4. Click **Save As**. If this is a change to a pre-existing filter, click **Save**.

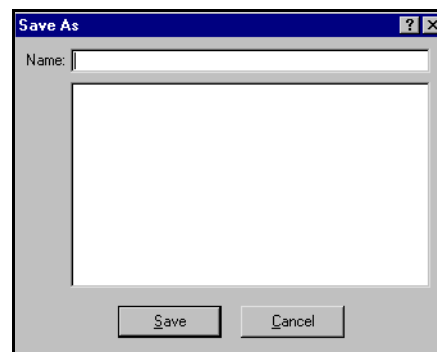


Figure 18-3: Save As Window

5. Enter the name for the filter.
6. Click **Save**.

Note: To delete a personal filter, select the filter from the list and click **Delete**. At the confirm deletion prompt, click **Yes**.

7. Click **OK**.

18.3 Setting Laboratory Module Preferences

The Preferences tab allows you to set default times and viewing options. Each time you open the Lab module, the listed results match these defaults. The Lab module is defaulted to display ten lab results. The default value can be changed, but this may impact your wait time and system performance.

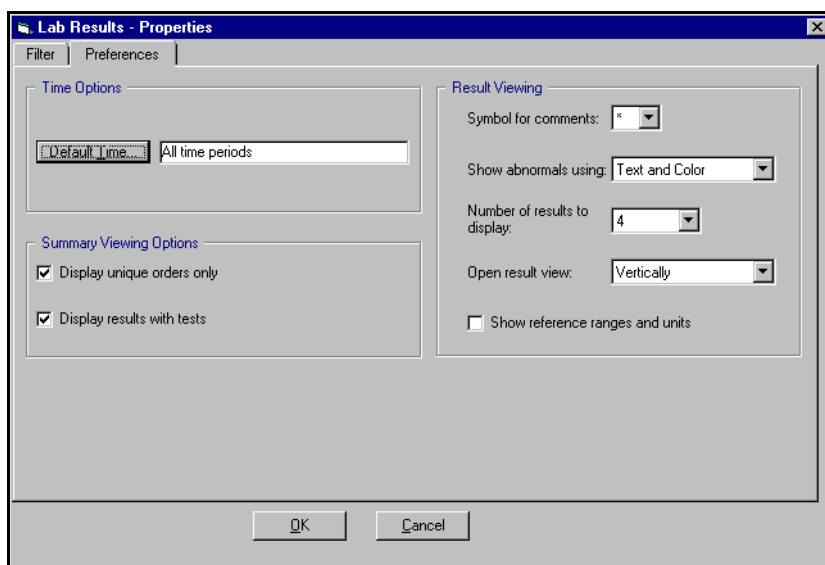


Figure 18-4: Lab Results—Properties Window—Preferences Tab

Follow the steps below to set Lab module preferences:

1. Click **Options** on the Lab module. The Lab Results Properties window opens.
2. Click the **Preferences** tab.
3. Click **Default Time**. The Lab Results warning window displays.

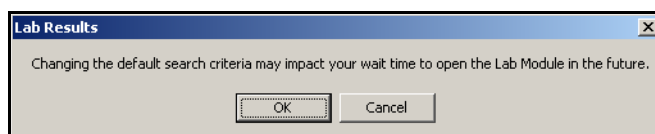


Figure 18-5: Warning Window

4. Click **OK**. The Time Search window opens.

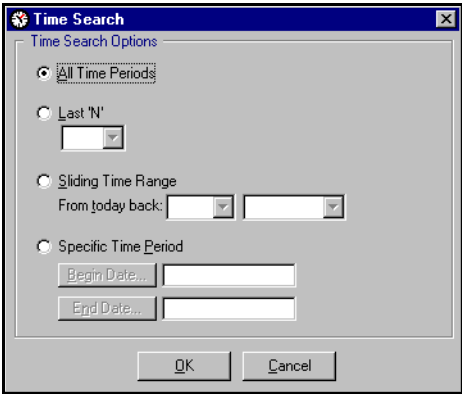


Figure 18–6: Time Search Window

5. Select the radio button for the applicable Time Search Option and click **OK**.

Note: The items in the Summary Viewing Options area have no bearing on the default display.

6. In the Result Viewing area, complete the following fields:
- **Symbol for comments:** This field has no bearing on the Lab module.
 - **Show abnormals using:** This field has no bearing on the Lab module.
 - **Number of results to display:** Select the number of results to be displayed in the Lab module.
 - **Open result view:** Select the desired view for the results. Options include vertically and horizontally.
7. Click **Show Reference Ranges and Units** to display units upon opening the Lab module.
8. Click **OK**.

18.4 Viewing Lab Results

Once the search criteria have been defined, the lab test results are displayed.

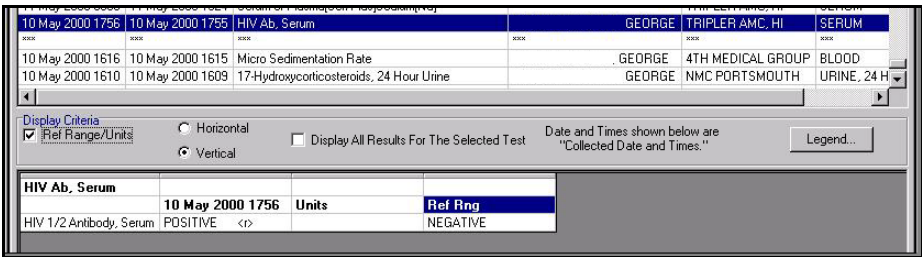


Figure 18–7: Lab Test Results

Select the desired test data to be viewed by selecting the test name. The data is displayed in the bottom of the Lab module. The Lab Result Profile area can be changed according to individual preference.

- **Display All Test Results:** Click **Select All Results** to view all test result data in the test viewing area simultaneously.
- **Ref Range/Units:** Select the check box to view the CHCS II normal range and unit for each test.
- **Change Viewing Format:** The layout of the results can either be seen vertically or horizontally. Select the appropriate radio button.
- **Legend:** Click **Legend** to view the codes used in the test results.

Tip:

To view any comments associated with the result, double-click on a cell with <o>, <i>, <r>, or <a> to view the order comments, interpretations, results comments, and amendments.

Note: Lab results cannot be printed directly from the Lab module. In order to print lab results, you must first copy the lab result to a note and then print it as part of a current encounter, or print the lab results from the Flowsheets module.

18.5 Viewing Sensitive Lab Results

Sensitive lab results are displayed with asterisks. Remaining columns are viewed as normal. You must have “break the glass” privileges to view sensitive lab results.

Follow the steps below to view sensitive results:

1. Double-click the result. A security message is displayed stating that all further actions are audited. If you do not have sufficient security privileges, a security message is displayed and you cannot proceed.

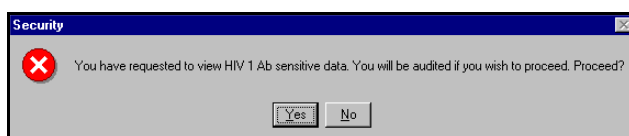


Figure 18–8: Security Warning

2. Click **Yes** to continue. The sensitive lab results are displayed in the bottom portion of the workspace.

18.6 Copying Lab Results to a Note

Details of a lab result can be copied to the clipboard or copied and placed directly into the S/O portion of the current patient encounter summary.

Follow the steps below to copy lab results to a note:

1. Select the desired result so the details are in the bottom of the Lab module.

The screenshot shows a software window titled 'Lab Results Window (Copy Lab Results)'. It has a search criteria section at the top with filters for 'All Orders', 'Time' (set to 'All time periods'), and 'Tests' (set to '40'). Below this is a table of lab results. The table has columns: Type, Date Collected, Date Ordered, Date Resulted, Report, Ordering Provider, MTF, and Site/Specimen. The 'Chem 17' row is highlighted. Below the main table is a 'Display Criteria' section with options for 'Ref Range/Units' (checked), 'Vertical' (selected), and 'Horizontal'. A 'Legend...' button is also present. At the bottom, there is a detailed view of 'Chem 17' with columns: Test / Result Name, Site/Specimen, Collection Date / Result Values, Units, and Ref Rng.

Type	Date Collected	Date Ordered	Date Resulted	Report	Ordering Provider	MTF	Site/Specimen
Standard Lab	25 Sep 2002 1340	25 Sep 2002 1340	25 Sep 2002 2134	Creatinine	MIL R, RI JALD	NMC Portsmouth	URINE
Standard Lab	25 Sep 2002 1340	25 Sep 2002 1340	25 Sep 2002 2134	Protein, 24 Hr Urine	MIL R, RI JALD	NMC Portsmouth	RANDOM
Standard Lab	25 Sep 2002 1340	25 Sep 2002 1339	25 Sep 2002 1514	Chem 17	MIL R, RI JALD	NMC Portsmouth	SERUM
Standard Lab	25 Sep 2002 1340	25 Sep 2002 1339	25 Sep 2002 1411	Urinalysis W/Microscopic	MIL R, RI JALD	NMC Portsmouth	URINE
Standard Lab	20 Aug 2002 1459	20 Aug 2002 1438	20 Aug 2002 1839	Chem 7	MIL R, RI JALD	NMC Portsmouth	SERUM
Standard Lab	13 Aug 2002 0815	13 Aug 2002 0815	14 Aug 2002 1455	Lipid Panel, Complete	GIA TTTC IO, J M	NMC Portsmouth	SERUM
Standard Lab	13 Aug 2002 0815	13 Aug 2002 0815	14 Aug 2002 1455	Alanine Aminotransferase	GIA TTTC IO, J M	NMC Portsmouth	SERUM

Test / Result Name	Site/Specimen	Collection Date / Result Values	Units	Ref Rng
Chem 17	SERUM	25 Sep 2002 1340		
AST	SERUM	30	IU/l	15-46
Albumin	SERUM	4.0	g/dl	3.4-5.0
Alk. Phos.	SERUM	86	IU/l	38-126
Bilirubin, Total	SERUM	0.4	mg/dl	0.0-1.3
CO2	SERUM	24	mmol/l	22-33
Calcium	SERUM	9.2	mg/dl	8.4-10.5
Chloride	SERUM	107	mmol/l	98-108
Creatinine, Serum/Plasma	SERUM	1.1	mg/dl	0.7-1.3
GGT	SERUM	20	IU/l	5-85
Glucose	SERUM	90	mg/dl	70-120
LDH	SERUM	464	IU/l	313-618
Phosphate	SERUM	4.3	mg/dl	2.4-4.6

Figure 18-9: Lab Results Window (Copy Lab Results)

Tip:

To select the results, click inside the top, left box. Continue holding down the mouse button and drag the mouse to the lower-right corner.

2. Select the result(s) you want to copy.
3. Perform a right-mouse click, then select either:
 - **Copy:** Copies the selection on the clipboard so it can be used in another location.
 - **Copy to Note:** Copies the details directly into the S/O portion of the current patient encounter summary.

Note: You must open an encounter to use the Copy to Note function. The result is pasted directly into the patient encounter. Once copied, the results cannot be deleted from the note, so ensure that you only select the **Copy to Note** option once, to avoid duplication.

Note: After you copy lab results into a note, you can print the lab results as part of an encounter by printing the electronic SF600.

18.7 Printing Lab Results

Lab results cannot be printed directly from the Lab module. Lab results can only be printed from the electronic SF600 as part of a current encounter after you copy the lab results to a note or lab results can be printed from the Flowsheets module.

19.0 LIST MANAGEMENT

19.1 List Management Overview

The List Management module allows you to create and manage various lists within CHCS II. These lists include Diagnoses, Procedures, and Complaints. The customized lists are available within various modules to streamline the documentation process.

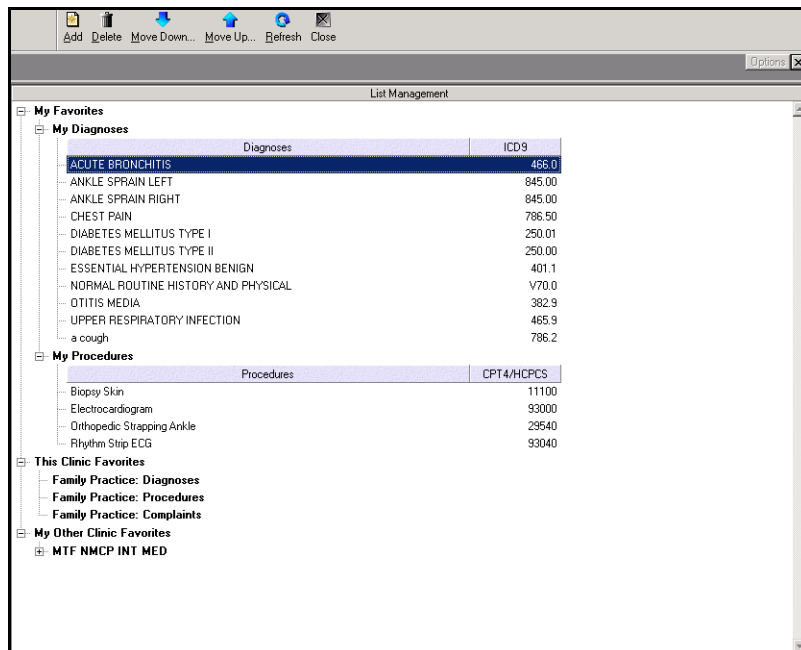


Figure 19-1: Military Clinical Desktop—List Management Module

19.1.1 In More Depth

Diagnoses and Procedures can be added to a user favorite list and all three items, including Complaints can be added as clinic favorites. When creating each list, the List Management module searches the MEDCIN nomenclature. The same nomenclature that is used in the Screening, S/O, A/P, Disposition, Problems, and Template Management modules. Because it uses the same organization of clinical findings, these lists are available in multiple modules.

Diagnoses:

- A/P module, Diagnosis tab
- Problems module, when adding a problem or Family History

Procedures:

- A/P module, Procedures tab
- Problems module, when adding a historical procedure

Complaints:

- Screening module

The creation of personal and clinic favorites lists can reduced the amount of time spent searching for common diagnoses, procedures, and complaints. You must have the appropriate privileges to add to or remove from a clinic list.

The personal favorites lists can be created in the A/P and Problems modules as well. Look for the **Add to Favorite List** button on the Diagnosis and Procedure tabs in the A/P module. In the Problems module, look for the **Add to User Favorites** checkbox when adding problems, historical procedures, or family history.

Once the personal favorites list is created, it is saved with your profile so your list is available from any computer in your clinic.

19.2 Adding an Item to a Favorites List

Follow the steps below to add an item to a Favorites List:

1. Select the list to which you want to add an item (i.e., My Diagnoses). The Add icon is not active until you select a list heading.
2. Click **Add** on the Action bar. The Select Diagnosis window opens.

Note: The title of the window changes, depending on the type of list you have selected to add (such as diagnosis, procedure, clinic, user).

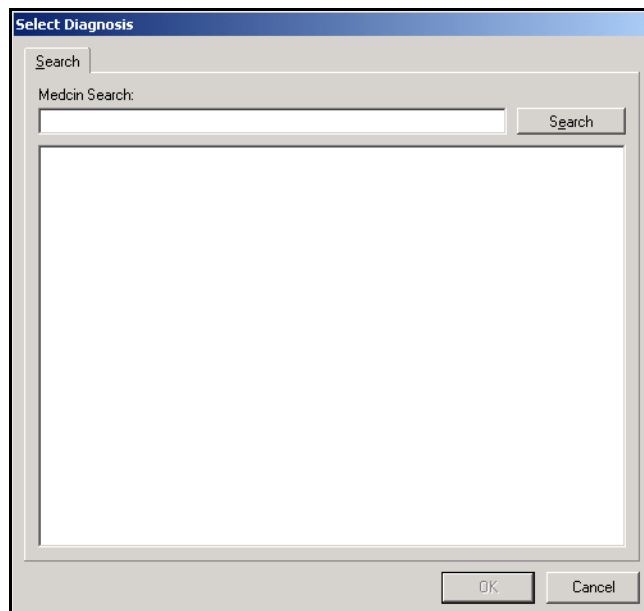


Figure 19-2: Select Diagnosis to Add to Clinic List Window

3. Enter search criteria.

4. Click **Search**. The bottom of the window populates with items matching the search criteria.
5. Select the item to be added.
6. Click **OK**. The new item is added on the List Management module.

Note: Each item is added to your list with its associated ICD or CPT code.

19.3 Deleting an Item From a Favorites List

Follow the steps below to delete an item from a Favorites List:

1. Select the item you want to delete from the Favorites List.
2. Click **Delete** on the Action bar.

19.4 Changing Location of Items on a List

Follow the steps below to change the location of an item on a list:

1. Select the item to want to relocate.
2. Click **Move Down** or **Move Up** until the item is where you want it.

Tip:
Organize your list for easy selection; most common to least common, or alphabetical.

20.0 MEDICATIONS

20.1 Medications Overview

The Medications module lists the patient's past and present medications. The list includes over-the-counter (OTC), outside, and CHCS II-ordered medications. Current medications can be viewed, re-ordered, or modified and new medications can be added and ordered. Only OTC/Outside medications can be documented without an open encounter. A current encounter must be open in order to re-order, modify, or order new medications.

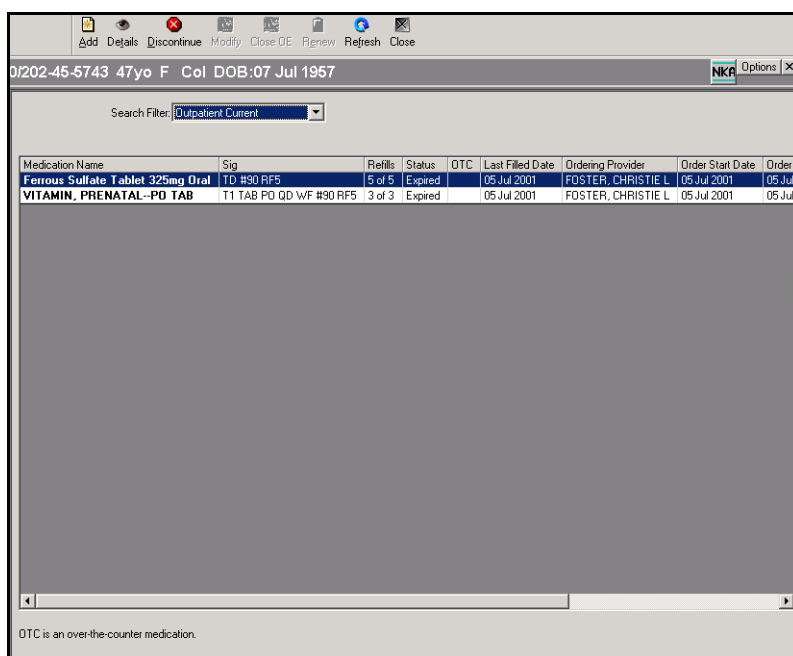


Figure 20-1: Military Clinical Desktop—Medication Module

20.1.1 In More Depth

Typically, a medication is ordered through the A/P module and is sent to CHCS for processing. Once the prescription has been filled in the pharmacy, the medication is displayed in the Medication module in CHCS II.

Information available for each entry includes the SIG, quantity, refills, days supply, dispensing location, clinic, status of the prescription, order information, and ordering end user.

The default list of medications includes outpatient current medications for patients with an appointment classification of Outpatient. When the Medications module is opened for a patient whose classification is Inpatient, the default filter is Inpatient Current.

In the list of medications, active medications appear in bold text and inactive medications appear in regular text. Those medications that were added as an OTC/Outside medication will have a check in the OTC column.

20.2 Setting the Filter of the Medications Module

The default filter, either Outpatient Current or Inpatient Current, can be changed. The Properties window in the Medications module contains the Default Filter drop-down list. The Default Filter is used to set the default Search Filter in the Medications module.

Follow the steps below to change the filter:

1. Click **Options** on the Medications module. The Properties window opens.

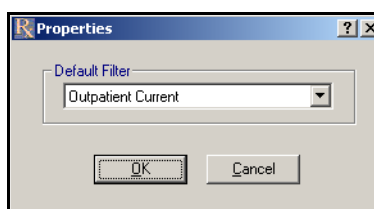


Figure 20-2: Properties Window

2. Select the desired filter from the Default Filter drop-down list.

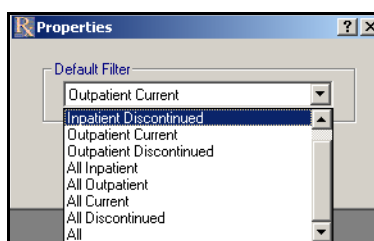


Figure 20-3: Default Filter Drop-Down List

3. Click **OK**. The list of medications is refreshed based on the selected filter.

20.3 Documenting an OTC/Outside Medication

An OTC/Outside medication can be documented in the Medications module. Medications added as an OTC/Outside medication are not considered during the pre-verify process that occurs when a medication is ordered. There are no drug-drug, drug-allergy, or duplicate order warnings based on these documented medications.

Follow the steps below to document an OTC/Outside medication:

1. Click **Add** on the Action bar. The Select Type of New Medication window opens.

Note: In order to add new medications, an encounter must be open and the filter must be set to Outpatient Current.

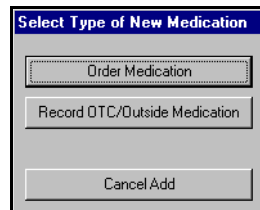


Figure 20–4: Select Type of New Medication Window

2. Click **Record OTC/Outside Medication**. The New OTC/Outside Medication pane opens at the bottom of the workspace.

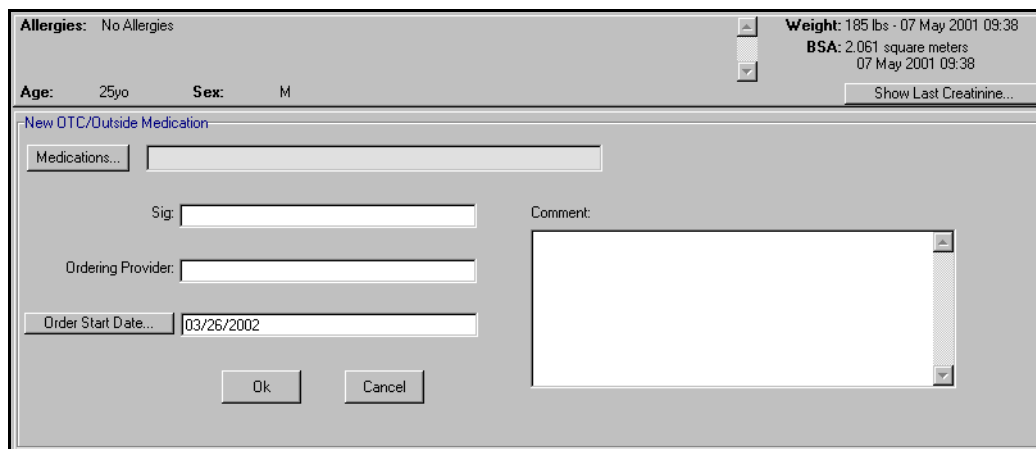
A screenshot of the "New OTC/Outside Medication" window. At the top, it shows patient information: "Allergies: No Allergies", "Age: 25yo", "Sex: M", "Weight: 185 lbs - 07 May 2001 09:38", and "BSA: 2.061 square meters 07 May 2001 09:38". There is a "Show Last Creatinine..." button. Below this is a section titled "New OTC/Outside Medication" with a "Medications..." button and a text input field. Further down are fields for "Sig:", "Ordering Provider:", and "Order Start Date..." (which has "03/26/2002" entered). To the right of these is a large "Comment:" text area. At the bottom are "Ok" and "Cancel" buttons.

Figure 20–5: New OTC/Outside Medications Window

3. Click **Medications** to search for and locate the medication.
4. Enter the name of the medication and click **Search**.
5. Select the correct medication and click **OK**.
6. On the New OTC/Outside Medication window, complete the following fields:
 - Sig: free text field
 - Ordering Provider: free text field
 - Order Start Date: Click **Order Start Date** to enter the correct date using the calendar or enter the date directly in the Start Date field.
 - Comment
7. Click **OK**. The OTC is added to the patient's medication list.

20.4 Ordering a New Medication

Tip:
To add a new medication, you must set the filter to **Outpatient Current**.

Medications can be ordered directly from the Medications module if an encounter is open.

Follow the steps below to order a new medication:

1. Open the appropriate encounter.
2. In the Medications module, click **Add** on the Action bar. The Select Type of New Medication window opens.

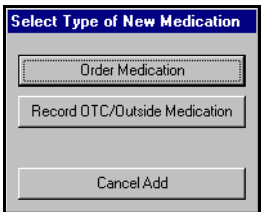


Figure 20–6: Select Type of New Medication Window

3. Click **Order Medication**. The New Order window displays at the bottom of the workspace.

A screenshot of the "Order Entry Medications Window". At the top is a "Search Filter" dropdown set to "Outpatient Current". Below is a table of medications with columns: Medication Name (Dispensed Only), Sig, Refills, Status, OTC, Last Filled Date, Ordering Provider, Order Start Date, and Order Expiration Date. Two rows are visible: "DIGOXIN (LANOXICAPS)-PO 0.05MG CAP" and "GLYBURIDE, 2.5MG". Below the table is a text area for "0 in OTC column indicates an outside medication". Further down are fields for "Allergies: No Known Allergies", "Weight: 155 lbs / 70.31 kg", "BSA: 1.814 square", "Age: 46yo", "Sex: F", "LMP: Not Recorded", and "Pregnant: No". The bottom section is titled "New Med Order" and contains a "Search" field, "Item Name" dropdown, "SIG" field, "Max Days Supply" and "Default Unit" fields, "Qty" and "Refills" fields, "Start Date" dropdown, "Expanded SIG" field, "Dispensing Location" dropdown (set to "YORKTOWN (NAVY) PHARMACY"), "Comments (Optional)" field, "Requesting Location" dropdown (set to "MSC YT"), and a "Child-Resistant Cap" checkbox. Buttons for "Clear", "Close", and "Submit" are at the bottom right.

Figure 20–7: Order Entry Medications Window

4. Enter the name of the medication in the Search field and click **Search**.
5. Select the medication from the results displayed in the Item Name field.
6. Complete the following fields:

- SIG

Note: If a CHCS sig exists for the selected medication, it auto-populates this field. The SIG can be edited and changed.

- Quantity
 - Refills
 - Start Date
 - Child Resistant Cap
 - Comment
 - Expanded SIG
 - Requesting Location
 - Dispensing Location
 - Ordering Provider
7. When all the necessary information has been added, click **Submit**. The ordered medication displays on the medication list once it has been filled by the pharmacy.

Note: CHCS pre-verifies the order against patient and medication records and displays any resulting messages or warnings, as well as any SIG code(s) and standard order/refill quantities associated with the medication. Warnings include duplicate orders and drug–drug and drug–allergy interactions. To override a warning in the Warnings window, enter a reason for the override and click **Accept Override**. To ignore the warning override, click **Cancel Order**.

20.5 Reviewing a Medication

Follow the steps below to review a medication:

1. Select the medication you want to review.
2. Click **Details** on the Action bar. The Details window opens and is read-only.

Allergies: TETRACYCLINES, ASPIRIN FREE ANALGESIC (ACETAMINOPHEN/PHENYLTOX CIT)		Weight: 185 lbs - 07 May 2001 09:38
		BSA: 2.061 square
Age: 26yo	Sex: M	Show Last Creatinine...
Review Medication:		
Medication Name		NDC
AMOXICILLIN-PO 250MG CAP		No NDC
Sig: T1 CAP PO TID F10 #7 RFO	Status: Expired	Order Number: 020124-00070
Quantity: 7	Order Start Date: 24 Jan 2002	Comment:
Refills: none	Order Expiration Date: 03 Feb 2002	NONE
Refills Remaining: 0	Last Filled Date: 24 Jan 2002	
Days of Supply: 10	Event Date: 24 Jan 2002@1147	
Dispensing Location: PORTSMOUTH MAIN PHARMACY		
Clinic: DERMATOLOGY NMCP	Ordering Provider: PROVIDER, DAVID	Close Detail

Figure 20–8: Details Window

3. Click **Close Detail**.

Tip:

You can still view information for a discontinued medication by setting up a filter that displays discontinued medications.

20.6 Discontinuing a Medication

Both ordered and OTC/Outside medications can be discontinued from the Medications module. An encounter must be open, though, to discontinue an ordered medication.

Follow the steps below to discontinue a medication:

1. Select the medication to be discontinued.
2. Click **Discontinue** on the Action bar.

Note: There is no confirmation message when discontinuing an ordered medication.

3. At the Inactive Medications confirmation prompt, for an OTC/Outside medication, click **OK**.

Note: There is no confirmation message when discontinuing an ordered medication. A message is displayed stating that the medication has been successfully discontinued.

20.7 Renewing a Medication

When the renew action is taken from the Medication module, the system automatically brings up the Order Entry Medication window. This function is only available for prescriptions that were originally ordered through the pharmacy and if an encounter is open.

Follow the steps below to renew a medication:

1. Select the medication to be renewed.
2. Click **Renew** on the Action bar. The Order Entry Medication window opens.

Search Filter: Outpatient Current

Medication Name (Dispensed Only)	Sig	Refills	Status	OTC
ZAZITHROMYCIN-PO 250MG TAB	2 TABS PO ON DAY ONE, THEN ONE DAILY UNTIL FINISHED #6 RFD	NR	Expired	1...
SODIUM CHLORIDE--0.225% SOLN	T1 T8 PO BID RFD	NR	Expired	1...
ASPIRIN/CAFF/BUTALBITAL (FIORINAL)-PO TAB	AS NEEDED #50 RFD	NR	Expired	0...
GUAIFENESIN/CODEINE (ROBI AC EQ.)-PO SYRP	AS DIRECTED #120 RFD	NR	Expired	0...

0 in OTC column indicates an outside medication

Allergies: SALT PETER (POTASSIUM NITRATE)

Weight: 185 lbs - 20 Nov 2001 15:45
BSA: 2.061 square meters
20 Nov 2001 15:45

Age: 40yo Sex: M

Show Last Orderline

New Med Order

Item Name: [Search]

SIG: [Expand SIG]

Qty: [Max] [Days Supply] [Default Unit]

Refills: [Maximum] Start Date: 03 May 2002

Expanded SIG: [Expand SIG]

Note to Provider: [Note to Provider]

☒ Child-Resistant Cap

Comments: (Optional)

Clear Close Submit

Requesting Location: DERMATOLOGY NMCP

Dispensing Location: [Dispensing Location]

Figure 20-9: Order Entry Medication Window

3. Change the SIG, Quantity or Refills, as appropriate.
4. Click **Submit**.

21.0 NEW RESULTS

21.1 New Results Overview

The New Results module displays a list of completed radiology procedures and laboratory tests. Once a procedure or test is filed and certified in CHCS, the order is displayed in the New Results module, allowing you to keep track of orders you have placed. You can either view a high level summary or detailed result information for a specific order. New Results can be viewed, discarded, tossed after viewing, forwarded to another Provider, or saved within the New Results module.

Patient Name	Result Type	Priority	Test Name	Critical/Abnormal
ALEXANDER,VIOLET	LAB	ROUTINE	CBC W/o Diff	CRITICAL
ALEXANDER,VIOLET	LAB	ROUTINE	Urinalysis	
ALEXANDER,VIOLET	LAB	ROUTINE	Chem 7	
SUAREZ,EDUARDO	LAB	ROUTINE	Hemoglobin A1c	ABNORMAL
SUAREZ,EDUARDO	LAB	ROUTINE	Microalbumin, urine	
SUAREZ,EDUARDO	LAB	ROUTINE	Urinalysis	ABNORMAL
SUAREZ,EDUARDO	LAB	ROUTINE	Lipid Panel Complete	ABNORMAL
SUAREZ,EDUARDO	LAB	ROUTINE	Chem 17	ABNORMAL
ALEXANDER,VIOLET	RAD	ROUTINE	L Spine (1 View) Series Report	MINOR ABNORMALITY
ALEXANDER,VIOLET	RAD	ROUTINE	Right Ankle (Trauma) Series Report	NORMAL
ALEXANDER,VIOLET	RAD	ROUTINE	Ultrasound Pelvis Non Obstetric Report	ABNORMAL_PHONE REPC
SUAREZ,EDUARDO	RAD	ROUTINE	Right Shoulder (AP Internal/External Rotation) Series Report	MINOR ABNORMALITY
SUAREZ,EDUARDO	RAD	ROUTINE	Sinus Series Report	MINOR ABNORMALITY
SUAREZ,EDUARDO	RAD	ROUTINE	Chest PA And Lateral Series Report	NORMAL
BERG,OLAF	LAB	ROUTINE	Chem 7	
BERG,OLAF	RAD	ROUTINE	Right Ankle (Trauma) Series Report	NORMAL

Figure 21-1: Military Clinical Desktop—New Results Module

21.1.1 In More Depth

Typically, a lab test or radiology procedure is ordered in the A/P module of CHCS II and is sent to CHCS for processing. Once the procedure or test is filed and certified, the results are sent to the CDR, an Alert icon shows up in CHCS II, and the result appears in the New Results module, as well as either the Lab or Radiology module.

An electronic signature is generated when certain actions are performed in the New Results module. The following table illustrates the electronic signature process:

Table 1:

CHCS II New Results Action	CHCS Reaction	Electronic Signature Generated?
View new lab or rad result	New result displayed, but not reviewed	No
View new lab or rad result and toss result after viewing	New result reviewed	Yes
Discard new lab or rad result	Result removed from Review New Results screen	No
View and save new lab or rad result	New result reviewed	Yes
Forward new lab or rad result to another Provider that has not been saved	New result forwarded to another Provider's New List of Results or sent as mail	No

In the summary view, critical results appear in red and results that are normal or have minor abnormalities appear in black.

There are two tabs that make up the New Results module: New Results and Saved Results. The New Results lists all of the results that have been filed and certified in CHCS. The Saved Results tab lists those results that have been saved from the New Results tab.

21.2 Viewing New Results

The New Results module allows you to view detailed information for a selected result. The New Results module interfaces with the Lab and Radiology modules when viewing detailed result information, depending on the selected result.

Follow the steps below to view results:

1. On the New Results tab, select the result you want to view.
2. Click **View Result** on the Action bar.
3. View the result in the Lab or Radiology module.
4. When you are finished viewing the detailed result information, close the Lab or Radiology module to return to the New Results module.

21.3 Discarding New Results

The New Results module allows you to discard selected results. You can discard results without viewing them (i.e., the result appears in your New Results list, but the result was forwarded to you for a patient from another Provider).

Follow the steps below to discard results:

1. On the New Results tab, select the result you want to discard.
2. Click **Discard** on the Action bar.
3. At the discard confirmation prompt, click **Yes**.

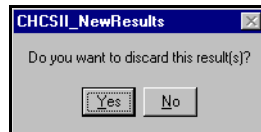


Figure 21-2: Discard Prompt Window

21.4 Saving New Results

The New Results module allows you to save selected results. Saving a new result removes it from the New Results tab and displays it on the Saved Results tab. You must first view the result before you can save it.

Follow the steps below to save results:

1. On the New Results tab, select the result you want to save.
2. Click **Save** on the Action bar.
3. At the save confirmation prompt, click **Yes**.

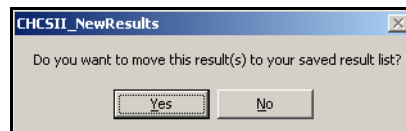


Figure 21-3: Save New Results Prompt

4. View the result on the Saved Results tab.

Patient Name	Result Type	Priority	Test Name	Critical/Abnormal	Date of Birth	Sex	FMP/SSN	Order Number	Exam Number
FRECHETTE, VELVA	RAD	ROUTINE	Right Ankle Series Report	NORMAL	09 JAN 1946	F	30/800-46-0109	020718-00008	02000480
GARRETT, AFTON	RAD	ROUTINE	Right Hip Series Report	NORMAL	10 SEP 1930	M	20/229-32-5444	020726-00010	02000497

Figure 21–4: Saved Results Tab

Note: Click **New** on the Action bar to move the results back to the New Results tab. At the confirmation prompt, click **Yes**.

21.5 Forwarding New Results

The New Results module allows you to forward new results to other Providers. When you forward a result to another Provider, a copy of the result is made and added to the forwarding Provider's New Results list. A Provider can only have a single copy of the result. If you forward a saved result to a Provider, the result displays in the forwarding Provider's New Results list.

Follow the steps below to forward a new result to a Provider:

1. Click **Provider Search** to locate the Provider to whom you are forwarding the new result.

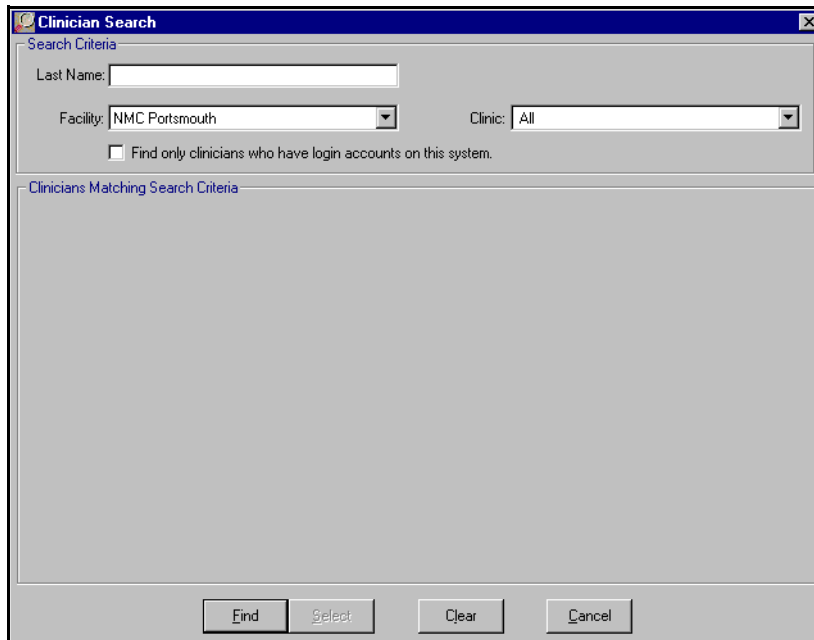


Figure 21-5: Clinician Search Window

2. In the **Last Name** field, enter the last name of the desired clinician.
3. Select a facility from the drop-down list.
4. Select a clinic from the drop-down list.
5. Click the **Find only clinicians who have login accounts on this system** to view only Providers associated with CHCS II.
6. Click **Find**. The results are displayed in the bottom half of the Clinician Search window.
7. Select the desired clinician.
8. Click **Select**.
9. On the New Results tab, select the result you want to forward.
10. Click **Forward** on the Action bar.
11. At the forward confirmation prompt, click **Yes**.

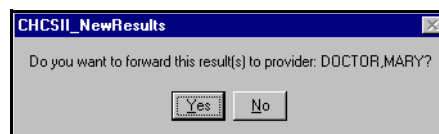


Figure 21-6: Forward Confirmation Prompt Window

21.6 Tossing New Results

The New Results module allows you to remove new results from the New Result list. You cannot toss a result that has not been viewed. If the result is on the Saved Results list, it has already been viewed and therefore can be tossed.

Follow the steps below to toss results:

1. On the New Results tab or Saved Results tab, select the result you want to toss.
2. Click **Toss** on the Action bar.
3. At the toss confirmation prompt, click **Yes**.

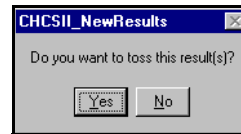


Figure 21–7: Toss New Results Prompt Window

22.0 ORDER SETS

22.1 Order Sets Overview

Order sets are templates of laboratory, radiology, or medication orders that streamline the ordering process. Order sets are created and saved as encounter templates and can be managed in the Template Management module. Once an order set has been created, it can be included in encounter templates.

22.1.1 In More Depth

Order sets can be created and organized in a variety of ways. Some users create order sets based on a specific diagnosis; diabetes, for example. Others create an order set template that includes the top twenty lab, radiology, and medication orders. This encounter template is then merged with disease- or symptom-specific encounter templates.

22.2 Creating an Order Set from A/P

Building an order set is not an intuitive process and must be done inside an open encounter. The best method is to use the A/P module to locate and save orders as part of an order set. Although orders should not be submitted as part of this process, it is best to be safe and create an appointment for a test patient in the test clinic.

Follow the steps below to create an order set from A/P:

1. In the A/P module, begin on one of the Order Entry tabs (Labs, Rads, or Meds).
2. Locate the first order you want to include in the order set.
3. When you have located the order, click **Save to Queue**. This saves the order without submitting it.
4. Continue with all three tabs, as appropriate, locating individual orders and clicking Save to Queue.

Tip:
Once an order has been submitted, it cannot be included in an order set. Orders must be located and then Saved to Queue.

Note: For Med and Rad orders, the SIG and clinical impression is used as the default for those orders. These can be changed when using the order set in an actual encounter.

5. Once you have finished locating the orders you want to include in your order set, click the **Order Set** tab to display the orders that have been saved to queue.

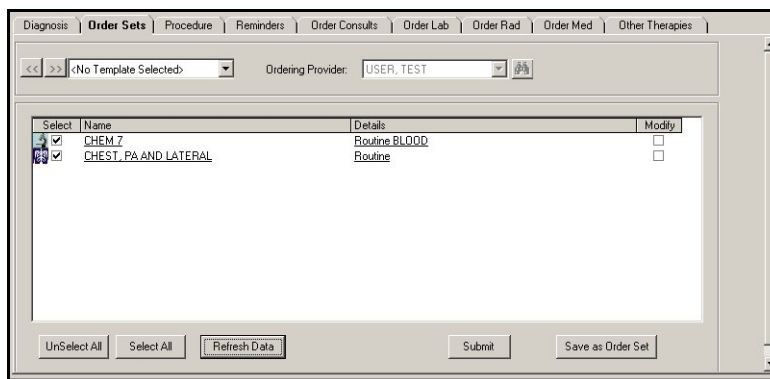


Figure 22-1: Order Sets Tab

6. Click **Save as Order Set**.
7. In the Save Encounter Template window **Template Name** field, enter the template name you want to use for the order set.
8. Click **Save** to save the order set. The order set encounter template can now be merged with other encounter templates and/or accessed in the Template Management and A/P modules.

22.2.1 Adding Orders to an Existing Encounter Template

An order set can also be saved as part of an encounter template that has already been built.

Follow the steps below to add orders to an existing template:

1. Locate your order(s) and save them to queue, following steps 1 - 4 above.
2. Once you have finished locating the order(s) you want to include in your order set, click the **Order Set** tab to display the orders that have been saved to queue.

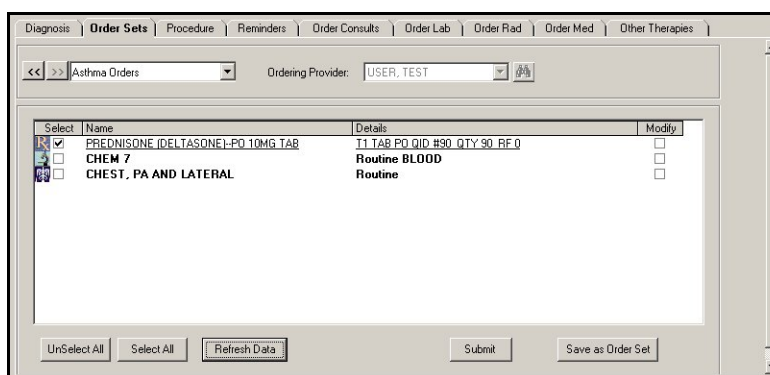


Figure 22-2: A/P Order Sets Tab

3. Click **Save as Order Set**.
4. In the Save Encounter Template window, select the encounter template to add to and click **Save**.

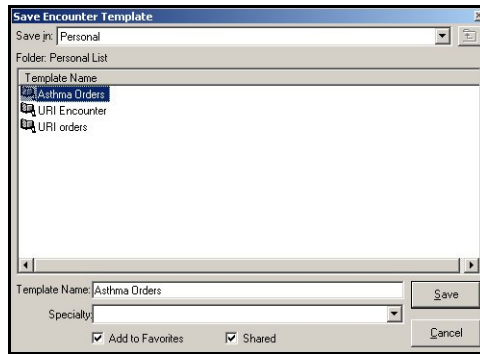


Figure 22-3: Save Encounter Template Window

5. A pop-up window opens asking if you want to Replace or Add To the existing template. Click **Add To**. The selected order(s) is(are) added to the existing template and can be viewed in the Template Management module or within A/P when the template is loaded.

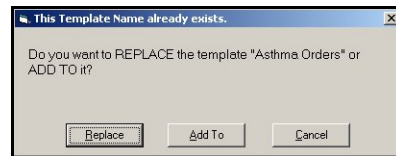


Figure 22-4: Template Name Option Box

22.3 Using an Order Set in A/P

Since an order set is considered an encounter template, you must select and load the Encounter template into the A/P module in order to view and use the associated order set.

Follow the steps below to load and use an order set:

1. Click the **Order Sets** tab.
2. If an encounter template with orders has not been loaded, use the template drop-down list to select the appropriate template. The orders associated with the Encounter template are available.

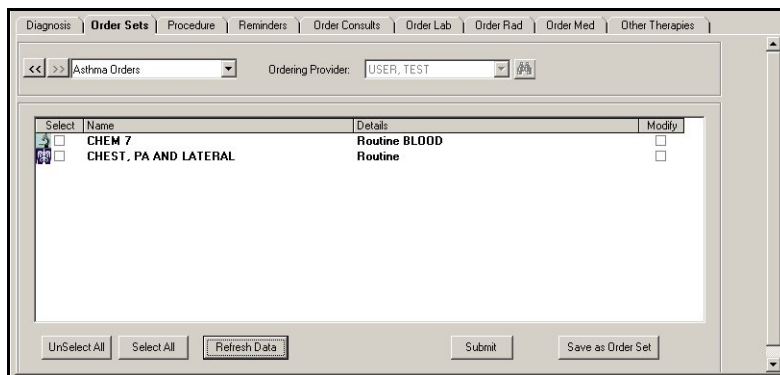


Figure 22-5: A/P Order Sets Tab

3. Do one of the following:

- If you want to select and submit all orders with no modifications, click **Select All**.
- If you want to select specific orders, click the checkbox in the Select column next to each applicable order.

Note: You can also click the checkbox in the Modify column next to each applicable order. Clicking a checkbox in the Modify column automatically puts a checkmark in the checkbox in the Select column.

4. Click **Submit**.

Note: Orders that were selected but not modified are sent out automatically. For orders needing modification, the appropriate order entry module opens. Make the desired modifications and click **Submit** on the order entry module.

23.0 PATIENT ENCOUNTER

23.1 Patient Encounter Overview

The CHCS II encounter document design is based on, and replaces, the SF600. Therefore, this module is commonly referred to as the electronic SF600. As the patient progresses through the clinic workflow and as clinical team members document the encounter, the Patient Encounter module collects and displays all of the documentation from each team member. It also contains buttons that correspond to each of the different sections of the entire note. This makes for easy navigation to the various modules that are used to document the encounter.

The screenshot displays the 'Patient Encounter Summary' window in the Military Clinical Desktop. At the top, a toolbar includes buttons for 'Refresh', 'Add Note', 'Add Providers', 'Templates', 'Sign', 'Save As Template', and 'Close'. Below the toolbar, patient information is shown: '01202-45-5743 47yo F Col DOB:07 Jul 1957'. The date is '04 Oct 2004 0922 EDT', status is 'In Progress', and MTF is '4th Medical Group'. The primary provider is 'PROVIDER, TERRY' and the type is 'ACUT'. The patient status is 'Outpatient' and the reason for appointment is 'Cough and fever'. The 'AutoCite' section is expanded, showing 'Problems' (METORRRHAGIA, IRON DEFICIENCY ANEMIA, ESSENTIAL HYPERTENSION, BENIGN), 'Allergies' (No Allergies Found), and 'Active Medications' (No Active Medications Found). The 'Screening' section is also expanded, showing 'Reason For Appointment: Cough and fever' and 'Allergen information verified by PROVIDER, TERRY @ 04 Oct 2004 0923 EDT'. The 'Vitals' section is expanded, showing 'Vitals Written by PROVIDER, TERRY @ 04 Oct 2004 0923 EDT' and 'Reason(s) For Visit (Chief Complaint): UPPER RESPIRATORY INFECTION (New); LMP: 30 Sep 2004. Birth Control Method: Birth Control Pill'. The 'S/O' section is expanded, showing 'SO Note Written by PROVIDER, TERRY @ 04 Oct 2004 0924 EDT' and 'Chief complaint: The Chief Complaint is: URI symptoms'. The 'History of present illness' section is expanded, showing 'The Patient is a 47 year old female. Fever * No chills. Cough * Not coughing up sputum. No earache *, No nasal discharge *, and No throat pain * No myalgias'. The 'Past medical/surgical history' section is expanded, showing 'Asthma. No diabetes mellitus'. The 'Personal history' section is expanded, showing 'Behavioral history: Not smoking. Review of systems: Head symptoms: Headache. No sinus pain. Eye symptoms: No itching of the eyes.'

Figure 23-1: Military Clinical Desktop—Encounter Summary

23.1.1 In More Depth

The encounter document is the central interface for documenting the patient encounter, including documenting the S/O portion, performing the assessment and plan, recording the patient disposition and signing the encounter.

At the top of the Patient Encounter module is the AutoCite area. This customizable area contains patient information that is already known about the patient. Information is pulled from various CHCS II modules, including Allergies, Problems, Medications, Vital Signs and the result retrieval modules.

The encounter document workspace has a row of buttons along the left margin and the text display area to the right. The buttons are used to access the different modules within the encounter both to enter new information and review and/or edit current

information. Modules accessible from this area include Screening, Vitals, S/O, A/P, and Disposition.

As data is entered into each of these modules, it displays in note form in the related workspace once the entry module is closed. When you have completed the encounter, this encounter document displays all the information documented for the patient visit.

This workspace design and application functionality support team-based care and the clinic workflow. Multiple individuals can work within one encounter at the same time. The system places time, date, and name stamps on each entry added to the encounter note.

Once the support staff, nurse, and provider gather all the information, the encounter is signed by the provider assigned to the encounter when the appointment was made.

23.1.2 Setting the Properties of the Patient Encounter Module

In the Patient Encounter module, the Signature Block and the items in AutoCite can be customized. Once set, these configurations become the default for every encounter you open.

Follow the steps below to set the properties of the Patient Encounter module:

1. Click **Options** in the top, right corner of the Patient Encounter module. The Encounter Summary Properties window opens.

Figure 23–2: Encounter Summary Properties Window

2. In the Signature Block, enter the text you want for lines 2 and 3.

Note: Line 1 defaults to you and cannot be changed.

3. If you need a co-signer for every encounter you sign, click **Search** to assign a default co-signer. The Clinician Search window opens allowing you to search for a provider to select as a co-signer.

Note: With a default co-signer selected, each time you sign an encounter, an alert is triggered for the co-signing provider.

4. In the AutoCite Preferences area, click the check box next to the items you want to AutoCite. A check denotes the selected items.
 - **Active Problems, Allergies, Active Medications, Active Family History, Questionnaire, Expired Medications:** Click the checkboxes to AutoCite the patient's information. The AutoCited information is pulled from the Problems, Medications, Allergy, and Patient Questionnaire modules.
 - **Vitals, Labs, Rads:** Select the checkboxes to AutoCite the patient's information. In the **Last** field, enter a numerical value and select the radio button to select the time setting.
 - **A/P Active Order Default:** Select the checkbox(es) if you want to display active medication, laboratory, or radiology orders when opening order entry tabs.
 - **Autosave S/O:** Enter a numeric value to denote the frequency of the autosave. The system saves the Form Tool or List Tool Notes according to this setting.
5. In the Disposition Follow Up Discussed with Default area, click the drop-down list and select the person with whom the disposition follow up is discussed.
6. Select the Auto-Print checkbox to auto-print.
7. Select the Auto-save S/O checkbox to have the encounter automatically save S/O at designated intervals. Click in the **Min** checkbox and enter the time.

Note: When vitals, labs, or rads are selected to AutoCite, additional fields become active. In the **Number** field, enter the desired number and then select the appropriate radio button. The system AutoCites vitals, labs, and rads according to these settings.

8. Click **OK**. The settings are saved.

23.2 Adding a Note

You can add a note to the Encounter Document. This narrative appears in the note section of the Patient Encounter module with the Time, Date, and user name next to the narration.

Follow the steps below to add a note:

1. On the Patient Encounter module, click **Add Note** on the Action bar. The Select Note window opens.

Tip:
For efficient system performance, it is recommended to only select those items that are needed for every encounter. CHCS II pulls this information from the CDR and large amounts of data could delay this process.

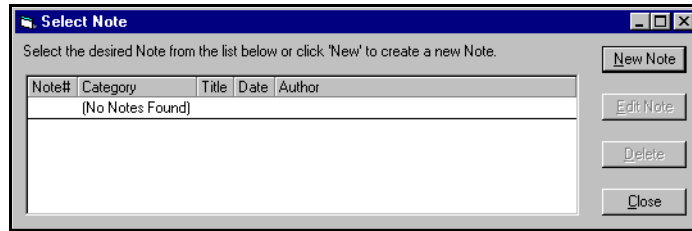


Figure 23-3: Select Note Window

2. Click **New Note** to begin a new note. The Encounter Note window opens, allowing you to add notes to any phase of the encounter.

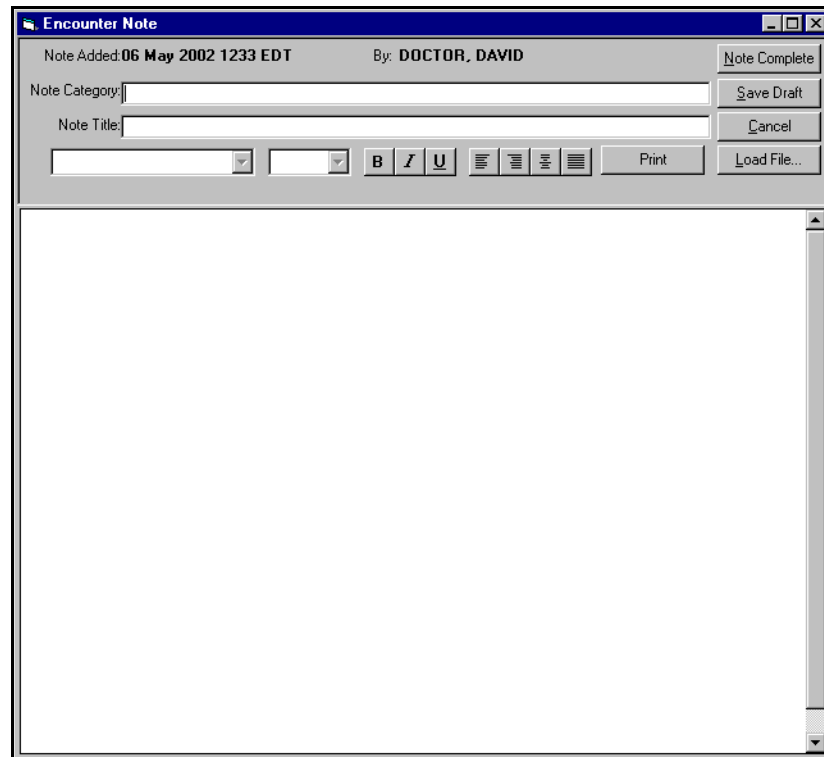


Figure 23-4: Encounter Note Window

3. Enter a **Note Category**, if necessary.
4. Enter a **Note Title**, if necessary.
5. Enter a note in the text box.
6. Do one of the following:

- If you want to insert a file into the note:
 - a. Click **Load File**.
 - b. Select the desired file to be added.
 - c. On the Select Destination File window, click **Open**.

Note: Graphics that are imported must be 500K or less.

- If you want to print the note for your hardcopy records, click **Print**.
7. Click **Note Complete**. The note appears in the encounter document.

Note: Click **Save Draft** to save the note as a draft. The note is displayed on the Patient Encounter module in the Note section as a draft. The encounter cannot be signed if a note exists in draft form.

23.3 Deleting a Note

Follow the steps below to delete a patient encounter note:

1. On the Patient Encounter module, click **Add Note** on the Action bar. The Select Note window opens.

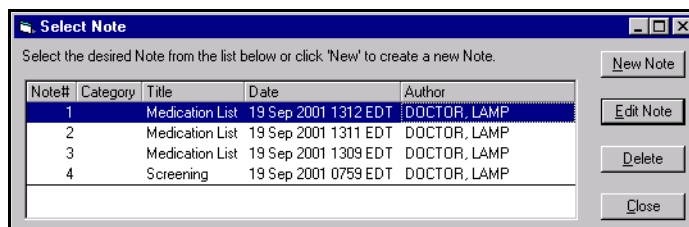


Figure 23-5: Select Note Window (With Data)

2. Select the note you want to delete.
3. Click **Delete**.
4. Click **Yes**. The Confirm Deletion of Note message appears.

23.4 Editing a Note

Follow the steps below to edit a note:

1. On the Patient Encounter module, click **Add Note** on the Action bar. The Select Note window opens.
2. Select the note you want to edit.
3. Click **Edit Note**. The Encounter Note window opens.

The screenshot shows a software window titled "Encounter Note". At the top, it displays "Note Added: 06 May 2002 1236 EDT" and "By: DOCTOR, DAVID". Below this are input fields for "Note Category:" and "Note Title: Referral Information". To the right of these fields are buttons for "Note Complete", "Save Draft", and "Cancel". Below the input fields is a toolbar with a font dropdown set to "Arial", a size dropdown set to "8", and buttons for bold (B), italic (I), underline (U), bulleted list, numbered list, and indent. There are also "Print" and "Load File..." buttons. The main text area contains the text "Patient is requesting a referral for MRI." and has a vertical scrollbar on the right.

Figure 23–6: Encounter Note Window (Edit Mode)

4. Make the applicable edits to the note.
5. Click **Note Complete**.

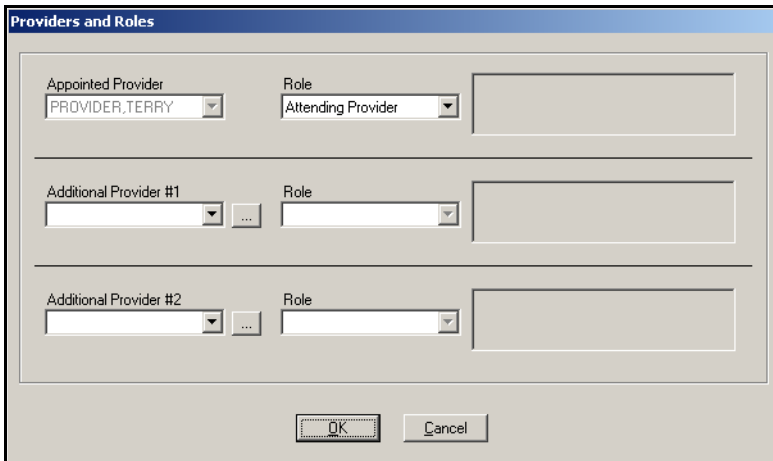
Note: If the note you are editing has been created by another person, a message prompt appears asking if you want to create a note starting with the contents of the note you selected—click **Yes** to use the contents of the selected note, or **No** to create a note with no previous contents.

23.5 Adding an Additional Provider

An additional provider can be added to an encounter to receive credit for work performed on a patient.

Follow the steps below to add an additional provider:

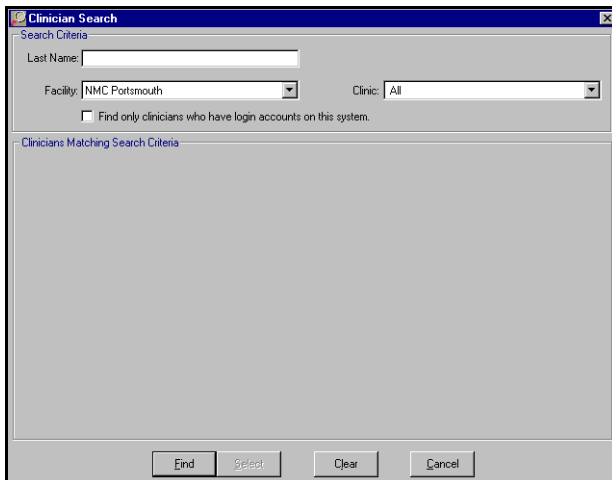
1. On the Action bar, click **Add Providers**. The Provider and Roles window is displayed.



The **Providers and Roles** window contains three sections for adding providers. The first section, **Appointed Provider**, has a dropdown menu showing 'PROVIDER, TERRY' and a 'Role' dropdown menu showing 'Attending Provider'. The second section, **Additional Provider #1**, has an empty dropdown menu, an ellipsis button (...), and an empty 'Role' dropdown menu. The third section, **Additional Provider #2**, also has an empty dropdown menu, an ellipsis button (...), and an empty 'Role' dropdown menu. At the bottom are 'OK' and 'Cancel' buttons.

Figure 23-7: Providers and Roles Window

2. Select the type of clinician you want to add.
3. In the **Additional Provider #1** area, click the **ellipsis** button to search for a provider. The **Clinician Search** window opens.



The **Clinician Search** window has a 'Search Criteria' section with a 'Last Name' text field, a 'Facility' dropdown menu (showing 'NMC Portsmouth'), and a 'Clinic' dropdown menu (showing 'All'). Below these is a checkbox labeled 'Find only clinicians who have login accounts on this system.' The bottom half of the window is a large empty area labeled 'Clinicians Matching Search Criteria'. At the bottom are 'End', 'Select', 'Clear', and 'Cancel' buttons.

Figure 23-8: Clinician Search Window

4. In the **Last Name** field, enter the last name of the desired clinician.
5. Select a facility from the drop-down list.
6. Select a clinic from the drop-down list.
7. Click the **Find only clinicians who have login accounts on this system** to view only providers associated with CHCS II.
8. Click **Find**. The results are displayed in the bottom half of the **Clinician Search** window.
9. Select the desired clinician.
10. Click **Select**. The name populates in the **Additional Provider** field on the **Provider and Roles** window.

11. Click the Role drop-down list to select the additional provider's role.

Note: Repeat steps 2-11 if you want to add a second additional clinician.

12. Click **OK**. The clinician(s) is(are) added to the appointment.

23.6 Loading an Encounter Template

An Encounter Template can be selected and loaded into an encounter. The Encounter Template contains diagnoses, procedures, S/O templates, orders, and patient instructions. Encounter templates are typically loaded directly through the S/O or A/P modules to streamline the documentation process.

Follow the steps below to select an encounter template:

1. On the Patient Encounter module, click **Templates** on the Action bar. The Template Selections tab opens within the Template Management module.

Figure 23-9: Template Management Window—Template Selections Tab

2. Locate the template using one of the following methods:
 - Expand the My Favorites, Clinic, MTF, or Enterprise Folders.
 - Conduct a search for the template.
 - Enter the name of the template in the Name Search field and click **Find Now**. The search results display in the Name Search Results Folder.
3. Select the template.

- Click **Add**. The template is moved to the Selected Templates List.

Note: More than one template can be added to the encounter.

- Click **OK** to load the template(s) in the encounter. The Patient Encounter module opens with the embedded template(s).

Note: The template details are displayed within the S/O (Notes template) and A/P (Diagnoses, Procedures, Orders, and Patient Instructions) modules.

23.7 Signing the Encounter Overview

When the provider is satisfied that the encounter is complete, the final step in the encounter process is to sign the encounter. The primary provider performing the encounter documentation must sign the encounter.

23.7.1 Requirements for Signing an Encounter

If an encounter is incomplete, the Encounter is not Complete window opens explaining which sections are incomplete. The primary provider has the option to return to the current encounter to complete it.

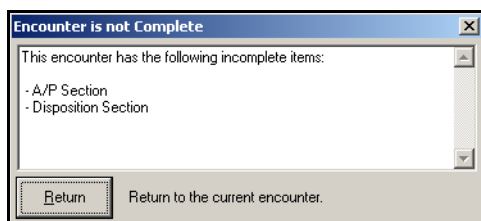


Figure 23–10: Encounter is not Complete Window

To be complete, an encounter must contain the following:

- At least one diagnosis
- Disposition
- E&M code

In addition, a note or consult cannot be in draft form. If the encounter is marked as related to an Injury/Accident an E-code (diagnosis) must be included as a diagnosis.

Follow the steps below to sign the encounter:

- Click **Sign** on the Action bar. The Sign Encounter window opens.

Sign Encounter

Patient: ALEXANDER, VIOLET	Date: 04 Oct 2004 0922 EST	Appt Type: ACUT
Facility: 4th Medical Group	Clinic: Gold MTF	Provider: PROVIDER, TERRY
Patient Status: Outpatient		

Reason for Appointment: Cough and fever

AutoCites Refreshed by PROVIDER, TERRY @ 04 Oct 2004 0922 EST

Problems • METRORRHAGIA • IRON DEFICIENCY ANEMIA • ESSENTIAL HYPERTENSION BENIGN	Allergies No Allergies Found.
---	---

Active Medications
No Active Medications Found.

Screening Written by PROVIDER, TERRY @ 04 Oct 2004 0933 EST

Reason For Appointment: Cough and fever

Allergen information verified by PROVIDER, TERRY @ 04 Oct 2004 0923 EDT

Reason(s) For Visit (Chief Complaint): UPPER RESPIRATORY INFECTION (New);
LMP: 30 Sep 2004. Birth Control Method: Birth Control Pill.

Vitals
Written by PROVIDER, TERRY @ 04 Oct 2004 0923 EDT
BP: 140/70, HR: 45, RR: 21, T: 100.3 °F, HT: 5' 3", WT: 114 lbs, BMI: 20.19, BSA: 1.523 square meters, Tobacco Use: No, Alcohol Use: No,

SO Note Written by PROVIDER, TERRY @ 04 Oct 2004 0924 EST

Chief complaint
The Chief Complaint is: URI symptoms

History of present illness
The Patient is a 47 year old female.

Enter Your Password: ☒ Auto-Print ☐ Sensitive

☐ Cosigner Required

Figure 23–11: Sign Encounter Window

2. In the **Enter Your Password** field, enter your password.
3. Do one of the following:
 - If you do not want to auto-print the signed encounter, deselect the **Auto-Print** checkbox. The system defaults to print the encounter summary.
 - If a co-signer is required:
 - a. Click the **Co-Signer Required** checkbox.
 - b. Click **Search**. The Clinician Search window opens.
 - c. Search for the clinician you want to designate as a co-signer.
 - If you want to mark the encounter as sensitive, click the **Sensitive** checkbox. The system marks the encounter as sensitive.

Note: When opening the Previous Encounters module that contains a sensitive encounter, asterisks display in place of the sensitive data. The provider must have “break the glass” privileges to view the data.

4. Click **Sign** to sign the encounter.

Note: Only the provider who was assigned the appointment can sign the encounter. Other Clinical Team Members can add to the encounter but cannot sign it.

23.8 Saving an Encounter as a Template

After an encounter has been documented, the structure and orders can be saved as an encounter template. No patient-specific information is saved. This action can be performed from the Patient Encounter and Previous Encounter modules.

Follow the steps below to save an encounter as a template:

1. Document the encounter.
2. On the Action bar, click **Save As Template**. The Template Details tab on the Template Management module opens. Details from the selected encounter display in their appropriate sections.

The screenshot shows the 'Template Details' tab in the Template Management window. It contains several sections for managing template data:

- Template Name:** Created from Encounter 106929
- Owner Type:** Personal
- User:** JONES, PAT
- Specialty:**
- EM Code Category:**
- Associated Reasons for Visit:** Includes 'Add...' and 'Remove' buttons.
- Associated Appointment Types:** Includes 'Add...' and 'Remove' buttons.
- Associated Problems:** Lists 'a decrease in height 781.91', 'ANKLE SPRAIN RIGHT 845.00', 'ACUTE BRONCHITIS 465.0', 'ASTHMA MILD INTERMITTENT 493.90', and 'DIABETES MELLITUS TYPE II 250.00'. Includes 'Add...' and 'Remove' buttons.
- Items to AutoCite into Note:** Includes 'Add...' and 'Remove' buttons.
- Diagnoses:** Lists 'ANTERIOR DISLOCATION OF LENS PSEUDOPHAKIC 379.33'. Includes 'Add...' and 'Remove' buttons.
- Procedures:** Lists 'Pulmonary Function Tests Peak Flow 94150'. Includes 'Add...' and 'Remove' buttons.
- Notes Templates:** Lists '(List) URI'. Includes 'Add...' and 'Remove' buttons.
- Orders:** Lists '(Rad)CHEST,PA'. Includes 'Add...' and 'Remove' buttons.
- Other Therapies:** Lists 'Oral Fluids Frequent' and 'Return To Clinic If Worse Or New Symptoms'. Includes 'Add...' and 'Remove' buttons.

Figure 23–12: Template Management Window—Template Details Tab

3. Add or remove information from the following areas:
 - **Associated Reasons for Visit, Associated Problems, Associated Appointment Types:** These three areas are rarely used within CHCS II. These areas determine those templates that the system suggests when you go to load a template.
 - **Items to AutoCite into Note:**
 - Click **Add**.
 - Select an AutoCite selection from the list and click **Add Items**.
 - Click **Done** to return to the Template Details tab.
 - **Diagnoses, Other Therapies, Procedures:**
 - Click **Add** next to the appropriate section.
 - In the **Search Term** field, enter the first few letters of the procedure and click **Search**.

- Select the item from the search results and click **Add Items**.
 - Click **Done** to return to the Template Details tab.
 - **Notes Templates:**
 - Click **Add**.
 - Click **Search** to open the List Note Template Search window.
 - Enter search criteria in the window and click **Search**.
 - Select the note template and click **Add Items**.
 - Click **Done** to return to the Template Details tab.
4. Click **Save As** on the Action bar. The Save Encounter Template window opens.

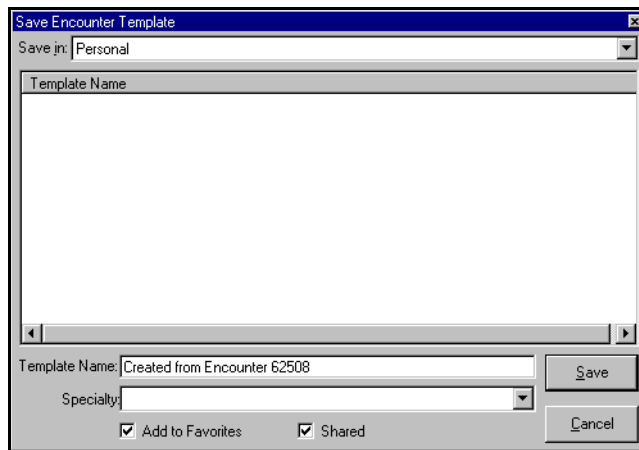


Figure 23–13: Save Encounter Template Window

5. Select the **template type** from the Save-in drop-down list.
6. In the **Template Name** field, enter the template name.
7. Select the **Specialty** from the drop-down list.
8. Click the checkboxes to denote whether the template should be added to your Favorites List or shared with other Clinical Team Members.
9. Click **Save**.

23.9 Unlocking an Encounter

More than one clinical team member can view and document a patient's record at the same time. The S/O Note is the only module of the current encounter that can be documented concurrently. If this is the case, both S/O notes are saved to the patient encounter. Only the primary provider can sign the encounter. The primary provider is the provider who owns the appointment.

23.9.1 Two Providers Accessing the Same Module

Two providers cannot document the A/P or the Disposition at the same time. If this occurs, a provider can take the section from the original provider. For example, if one provider is documenting A/P and a second provider accesses the A/P module, a message window appears, stating that A/P is being used and asks whether to break the lock. If the lock is broken, the second provider can document A/P. The original provider is informed upon saving A/P that this section was taken and no information from that section can be saved.

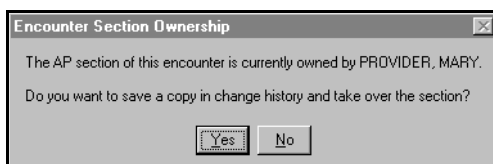


Figure 23–14: Encounter Section Ownership Window

23.9.2 Second Provider Changing First Provider's Information

A second provider can go behind the original provider and change the A/P or Disposition section of the encounter. When this occurs, the documentation done by the original provider is saved in the Notes section of the encounter under the heading of Change History.

24.0 PATIENT IMMUNIZATIONS

24.1 Patient Immunizations Overview

The Immunizations Module is used to manage and track patient immunization records and vaccine history. The Immunizations module contains two tabs: Individual Immunizations and Vaccine History. The Immunization module is patient-specific; therefore, a patient's record must be loaded to the desktop to access this module.

Immunization	Series	Date Given	Next Due
Hep A	1		Due Immediately
Influenza	1	04 Oct 2004	04 Oct 2005
Polio	1		Due Immediately
Td	1		Due Immediately
Typhoid	1		Due Immediately
Yellow Fever	1		Due Immediately

Figure 24–1: Military Clinical Desktop—Patient Immunizations Module

24.1.1 In More Depth

Active duty service personnel have a required set of immunizations that must be administered in order for the service member to be eligible for duty either in the United States or overseas. These immunizations can be administered at any DoD clinic and the immunization data must be updated.

The Individual Immunizations tab is used to select and administer vaccines to a patient and allows you to view immunization information. A color status indicator is used to quickly confirm immunizations that are current and those that are overdue per the established vaccine schedules for the individual vaccinations. The patient's allergy information is displayed as read-only data. The Vaccine History tab is used to add a vaccination to the patient's record, edit an immunization history, or delete an immunization history.

The recommended workflow for documenting CHCS II encounters in the Immunizations Clinic is as follows. Some of the steps may not be applicable based on each clinic's established business processes:

- Create a new walk-in appointment
- Open the appointment
- Document screening and verify allergies
- Document vital signs
- Administer immunization(s) to patient and document in CHCS II
- Print DD 2766C for the patient chart
- Document appropriate diagnostic and procedural codes in A/P module
- Document disposition
- Sign encounter

The DD Form 2766C in CHCS II is the Vaccine Administration Record. This form contains the same information as the SF 601 currently used in Immunizations clinics. For this reason, it is recommended that after the vaccinations have been documented in CHCS II, the end user should print the DD 2766C and place it in the patient's chart. It is not necessary to print the SF 600 for the patient's chart.

In the A/P module, a diagnosis and procedure code should be selected for each vaccine administered to the patient.

Note: A default encounter template should be created for use by the entire clinic staff to streamline the documentation process. The encounter template should contain all of the diagnostic and procedural codes used in the Immunizations clinic. The encounter template can also contain a S/O visit template to document the reason for visit as immunization.

If multiple vaccines are given for a single diagnosis, the appropriate procedure code for the first vaccine given should be associated to the diagnosis. The appropriate procedure code for each additional vaccine given should also be associated to the diagnosis. When administering multiple vaccinations, the users should use CPT multipliers to accurately document vaccines and generate accurate workload credit for the clinic.

24.2 Adding a Vaccination

Vaccinations can be added to a patient's record.

Follow the steps below to add a vaccination:

1. Click the Vaccine History tab on the Immunizations module. The Vaccine History tab displays.

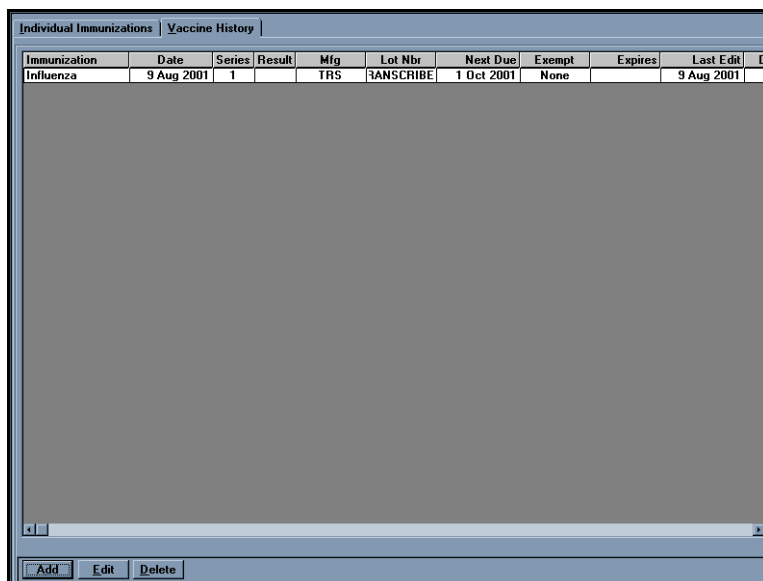


Figure 24–2: Immunizations module—Vaccine History Tab

- Click **Add**. The Vaccines window opens.

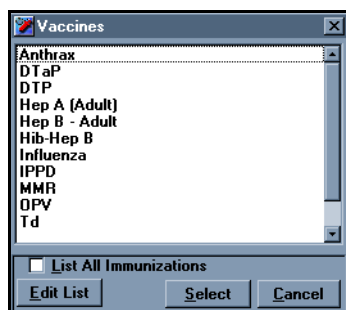


Figure 24–3: Vaccines Window

- Select the vaccine you want to add.

Note: Click the List All Immunizations checkbox to view a list of all vaccines in stock. All vaccines in stock appear on the list. Click **Edit List** to edit the list of favorite vaccines. On the Edit Favorite Vaccine List window, select a vaccine from the All Vaccines list and click the **right arrow** to move the vaccine to the Selected Vaccines list. Click **Close**.

- Click **Select**. The Add Vaccine window opens.

The screenshot shows a software window titled "ADD: BARTON CLARA H CPO 80657050120". Inside the window, there are several input fields and buttons. The "Vaccine" field is set to "Hep B - Adult". The "Vacc Date" field is empty with an ellipsis button. The "Series" field is set to "1". The "Manufacturer" dropdown is set to "Transcribed". The "Lot Number" field is set to "TRANSCRIBED". The "Dosage" dropdown is empty. The "Site" dropdown is set to "Unknown" and the "Route" dropdown is set to "UNK". The "VIS Version" field is empty with an ellipsis button. The "Next Vacc Due" field is empty with a "Recalc" button next to it. The "Exempt" dropdown is empty. The "Provider" dropdown is empty. At the bottom right, there are "Update" and "Cancel" buttons. The "Last Edited By" field is empty.

Figure 24–4: Add Vaccine Window

5. Complete the following fields:
 - **Vacc Date:** Enter a date, or click the **ellipsis** button and select a date from the calendar, to assign a vaccination date.
 - **Series Number:** Enter the series number of the vaccine, if necessary.
 - **Manufacturer:** Select a manufacturer from the drop-down list, if necessary.
 - **Lot Number:** Enter the lot number of the vaccine, if necessary.
 - **Dosage:** Select a dosage for the vaccine from the drop-down list, if necessary.
 - **Site:** Select an area of the body where the vaccine is given from the drop-down list, if necessary.
 - **Route:** Select the vaccine route from the drop-down list, if necessary.
 - **Next Vaccination Due:** Click **Recalc** to automatically calculate the next vaccination due date. The date is automatically entered.
 - **Exempt:** Select an exemption from the drop-down list, if necessary.
 - **Provider:** Select a provider from the drop-down list, if necessary.

Note: The Immunization Provider selected from the drop-down list should be the clinic team member who actually administered the vaccine(s) to the patient.

6. Click **Update** to save the data and return to the Vaccine History tab.

24.3 Deleting Immunization History

Follow the steps below to delete an immunization History:

1. Select the immunization you want to delete.

2. Click **Delete**.

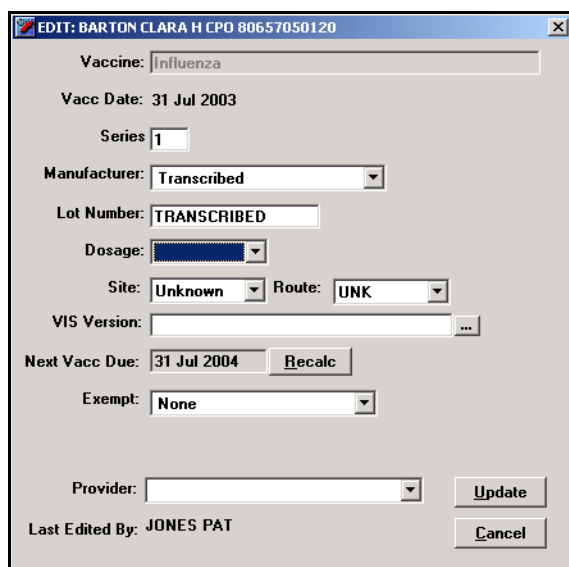
Note: You are not deleting the immunization from the patient's records, you are deleting vaccination history associated with the selected immunization.

24.4 Editing Immunization History

If you note any discrepancies between the patient's physical immunizations record and the CHCS II record, you can edit the electronic record to match the physical record. All new, modified, or deleted immunizations are automatically batch updated to DEERS. All immunization history data in DEERS for the patient is replaced with the contents of the database immunization record. This ensures consistent data for patients across all Services.

Follow the steps below to edit an immunization history:

1. Select the immunization you want to edit.
2. Click **Edit**. The Immunization History Edit window opens.



The image shows a software window titled "EDIT: BARTON CLARA H CPO 80657050120". The window contains the following fields and controls:

- Vaccine:** Influenza
- Vacc Date:** 31 Jul 2003
- Series:** 1
- Manufacturer:** Transcribed (dropdown menu)
- Lot Number:** TRANSCRIBED
- Dosage:** (dropdown menu)
- Site:** Unknown (dropdown menu)
- Route:** UNK (dropdown menu)
- VIS Version:** (text field with a browse button "...")
- Next Vacc Due:** 31 Jul 2004 (with a "Recalc" button)
- Exempt:** None (dropdown menu)
- Provider:** (dropdown menu)
- Update** button
- Cancel** button
- Last Edited By:** JONES PAT

Figure 24-5: Immunization History Edit Window

3. Complete the following fields:
 - Series
 - Manufacturer
 - Lot Number
 - Dosage
 - Site
 - Route

- Next Vacc Due
- Exempt
- Provider

4. Click **Update** to save the data and return to the Vaccine History tab.

24.5 Editing Vaccination Groups

All vaccination groups established for service type or occupational status are listed in the Vaccination Groups field.

The patient receives vaccinations assigned to the selected group(s).

Follow the steps below to edit the Vaccination Groups:

1. Click **Edit Groups** in the Individual Immunization tab. The Immunization Groups window opens.

Note: All vaccination groups established for service type or occupation status are listed in the Immunization Groups list. The vaccination groups assigned to the unit to which this patient belongs are shown in the Required Groups field. These groups are assigned in the Unit window, and cannot be edited. Groups defined by the support staff are listed in the User-Defined Groups field.

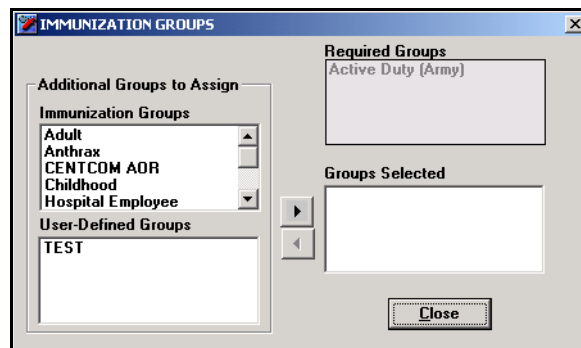


Figure 24–6: Immunization Groups Window

2. Select a group name from the Immunization Group or User-Defined Group list.
3. Click the **right arrow** to move the selected group to the Groups Selected list.

Note: Multiple groups can be selected to appear in the Vaccination Groups list.

4. Click **Close**. The selected groups appear on the Individual Immunization tab in the Vaccination Groups list.

24.6 Printing Immunization Records

There is an option to print the worksheet and the DD 2766C from the Individual Immunization window. The report prints to your default printer.

Follow the steps below to print immunization records:

- **Print Worksheet:** Use this function to print required immunizations for the selected patient.
- **Print DD 2766C:** Use this function to print a Vaccine Administration Record.

24.7 Reviewing Immunization Records

This area of the Individual Immunization tab displays all immunizations the patient is required to have based on the vaccination groups to which the patient is assigned. When immunizations are due, but have not been given, the column under Next Due displays in red. Once the required immunizations have been given through the Give VAX function, the column changes to green.

24.8 Selecting an Immunization

Follow the steps below to select an immunization:

1. Click **Give Vacc** on the Individual Immunizations tab. The Select Immunization window opens.

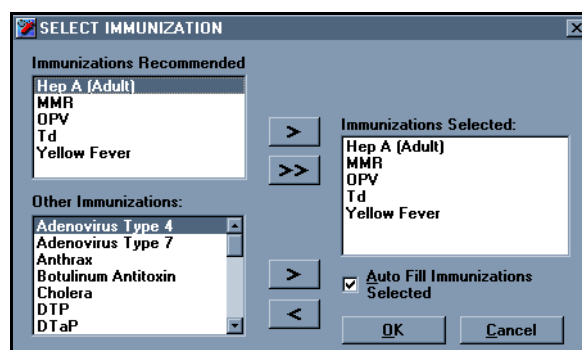


Figure 24–7: Select Immunization Window

2. Select an Immunization.

Note: The Immunizations Recommended list is based on the vaccination groups to which the patient is assigned. The Other Immunizations list is a list of all vaccines.

- Click the **right arrow** to move the items from the Immunizations Recommended list or Other Immunizations list to the Immunizations Selected list.

Note: Click the **double arrow** to move the entire group of Immunizations Recommended to the Immunizations Selected list.

Note: Click the **left arrow** to remove the selected immunization from the Immunizations Selected list back to the Immunizations Recommended or Other Immunizations list.

- Click **OK**. The Vaccine Select window opens displaying the selected vaccines.

Vaccine	Series	Mfg Code	Lot Nbr	Dose	Site	Route
Hep A (Adult)	1	CHI	856	1.0 mL	Left Arm	SC
MMR	1	OTC	6755	4 caps	Left Arm	Oral
OPV	1	AVI	222	2 gtts	Left Arm	IM
Td	1	NAB	29999	2 gtts	Left Arm	IM
Yellow Fever	1				Left Arm	

Figure 24–8: Vaccine Select Window

- Select the vaccine(s).
- Select the Immunization Provider from the drop-down list.

Note: The Immunization Provider selected from the drop-down list should be the clinic team member who actually administered the vaccine(s) to the patient.

- Click **OK**.

24.9 Selecting the Immunization Exempt Type

Follow the steps below to select the immunization exempt type:

- Global:** If a patient has never been given any of the immunizations that are listed in the vaccination record section, he/she can be exempted using this function from the Individual Immunization tab.
- Focused:** If an exemption has been given for that immunization, the exempt function must be performed from the Vaccine History tab.

Follow the steps below to make a global exemption for all immunizations in the Individual Immunizations tab:

1. Select an **Exempt Type** from the drop-down list.

Note: If you select **Medical (Temp)**, **Admin (PCS)**, or **Admin (Temp)** as an Exemption Type, an exempt date is required. The system formats that date.

2. Click, **Click to Save Exemption**.

Follow the steps below to make a focused exemption for a specific vaccination in the Vaccine History tab:

1. Select the vaccination to be exempted.
2. Click **Edit**. The Immunization History Edit window opens.

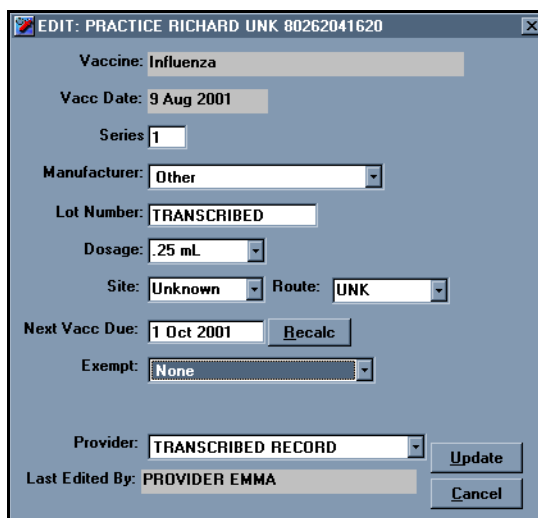
A screenshot of the 'EDIT: PRACTICE RICHARD UNK 80262041620' window. The window contains several fields: 'Vaccine: Influenza', 'Vacc Date: 9 Aug 2001', 'Series: 1', 'Manufacturer: Other' (dropdown), 'Lot Number: TRANSCRIBED', 'Dosage: .25 mL' (dropdown), 'Site: Unknown' (dropdown), 'Route: UNK' (dropdown), 'Next Vacc Due: 1 Oct 2001' with a 'Recalc' button, 'Exempt: None' (dropdown), 'Provider: TRANSCRIBED RECORD' (dropdown), and 'Last Edited By: PROVIDER EMMA'. At the bottom right are 'Update' and 'Cancel' buttons.

Figure 24–9: Immunization History Edit Window

3. Select the exempt type from the **Exempt** drop-down list.

Note: Depending on the reason, an exempt date may be required. The system formats the date.

4. Click **Update**. The Exempt Reason appears on the Vaccine History tab.

25.0 PATIENT LIST

25.1 Patient List Overview

The Patient List module displays your customized list of patients. You can set up the patient list to contain patients specific to your caseload. Typically, this module is used to manage patients frequently seen or patients with common problems. Patient records can also be accessed from this module.

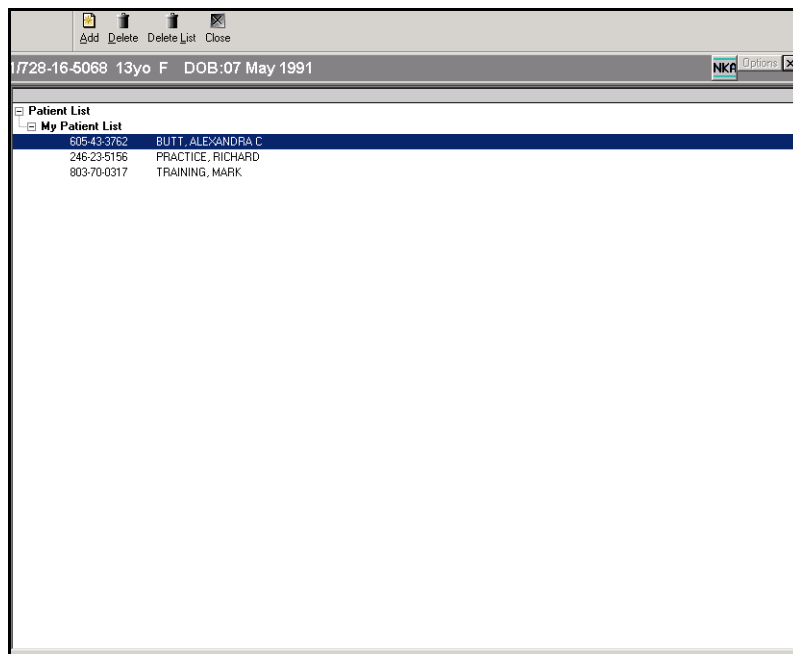


Figure 25-1: Military Clinical Desktop—Patient List Module

25.2 Adding a Patient Name

If the Patient List module is blank upon opening, no patients have been added.

Follow the steps below to add a patient name:

1. Click **My Patient List** on the Patient List window.
2. Click **Add** on the Action bar. The Patient Search window opens.

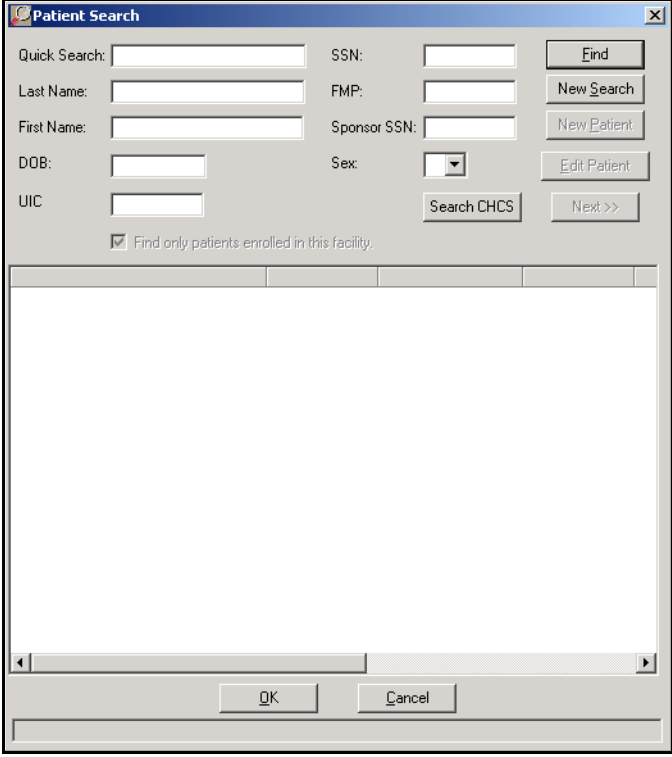
The image shows a 'Patient Search' window with a title bar and a close button. It contains several input fields: 'Quick Search:', 'Last Name:', 'First Name:', 'DOB:', 'UIC:', 'SSN:', 'FMP:', 'Sponsor SSN:', and 'Sex:'. There are also buttons for 'Find', 'New Search', 'New Patient', 'Edit Patient', 'Search CHCS', and 'Next >>'. A checkbox labeled 'Find only patients enrolled in this facility.' is checked. At the bottom, there are 'OK' and 'Cancel' buttons. The main area of the window is empty, suggesting a list of search results.

Figure 25-2: Patient Search Window

3. Conduct a patient search. The selected patient is displayed in the list.
4. Repeat the process until all desired patient names have been added.

25.3 Deleting a Patient Name

Follow the steps below to delete a patient name:

1. Select the patient name to be deleted from the Patient List module.
2. Click **Delete** on the Action bar. The Delete patient from list warning window opens.
3. Click **OK**. The patient name is deleted from the list.

25.4 Deleting the Entire List of Patients

Follow the steps below to delete the entire patient list:

1. Click **Delete List** on the Action bar. The Delete All Patients option window displays.
2. Click **OK**. All patient names are removed from your patient list.

26.0 PATIENT QUESTIONNAIRES

26.1 Patient Questionnaires Overview

The Patient Questionnaires module is used to administer questionnaires created in the Questionnaire Setup module. Patients can complete questionnaires by using a kiosk or through an interview process with a clinical team member. Patient questionnaires can be viewed, modified, and/or associated to an encounter.

From CHCS II, the end user is able to quickly navigate to the Patient Questionnaires module by loading a patient record and clicking Patient Questionnaires in the Folder List.

A questionnaire can be administered in Single Question or Multiple Question View. In Single Question View, questions are displayed one at a time as the patient completes the questionnaire. In Multiple Question View, all questions are displayed in the module as the patient completes the questionnaire.

The current practice for administering patient questionnaires is to interview the patient and document their responses on the electronic questionnaire in CHCS II. There is CHCS II functionality that allows the patient to use an assigned PIN to access and complete a questionnaire using a dedicated kiosk or other display device. Each MTF will determine how its clinics will use the Patient Questionnaires module to administer patient questionnaires.

26.2 Viewing Questionnaires in an Encounter Document

Follow the steps below to view a questionnaire in an Encounter document:

1. On the Patient Encounter module, click **Options**. The Encounter Summary Properties window opens.
2. In the AutoCite preferences area, select the **Questionnaires** checkbox.
3. Click **OK**.

26.3 Assigning a Questionnaire to a Patient

Follow the steps below to assign a questionnaire to a patient:

1. Within an open encounter, expand the Health History folder and select **Patient Questionnaires**. The Patient Questionnaires module opens.

Questionnaire/Test History				
Date	Questionnaire/Test	Encounter	Status/Score	Source
	Eds new questionnaire		PIN Assigned	Member Entry
	Eds new questionnaire		PIN Assigned	Member Entry
8/12/2004 1:52:05 PM	Eds Latest Questionnaire		Complete	Interview by PROVIDER, TERRY
8/12/2004 1:16:12 PM	Eds new questionnaire	48399	Complete	Interview by PROVIDER, TERRY
8/12/2004 1:12:59 PM	Eds new questionnaire		Complete	Interview by PROVIDER, TERRY
8/12/2004 1:12:30 PM	Eds new questionnaire		Complete	Interview by PROVIDER, TERRY
8/12/2004 1:09:58 PM	Eds new questionnaire	48399	Incomplete	Interview by PROVIDER, TERRY
8/11/2004 10:03:31 AM	Patient Satisfaction Survey for the MTF		Complete	Interview by WARDCLERK, BILL

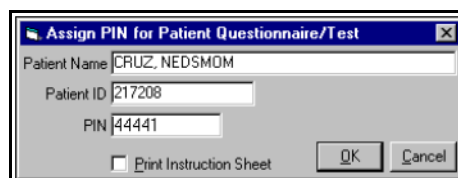
TEST, MALAVE
Eds Latest Questionnaire Version: 2
 Answer each question as honestly as possible

The selected provider for Eds Latest Questionnaire is PROVIDER, TERRY in the Gold MTF Clinic.

1. When was you last cholesterol check?
 Answer: 01 Jan 2004 (Enter answer using the following format 'dd mmm yyyy')

Figure 26-1: Questionnaire Module

2. Select the questionnaire that you want to assign to the encounter and click **Setup** from the Action bar. The Assign PIN for Patient Questionnaire/Test window opens.



Assign PIN for Patient Questionnaire/Test

Patient Name: CRUZ, NEDSMOM

Patient ID: 217208

PIN: 44441

☐ Print Instruction Sheet

OK Cancel

Figure 26-2: Assign PIN for Patient Questionnaire/Test

3. The patients are then supplied with the login credentials that they use at the kiosk to answer the questionnaire.

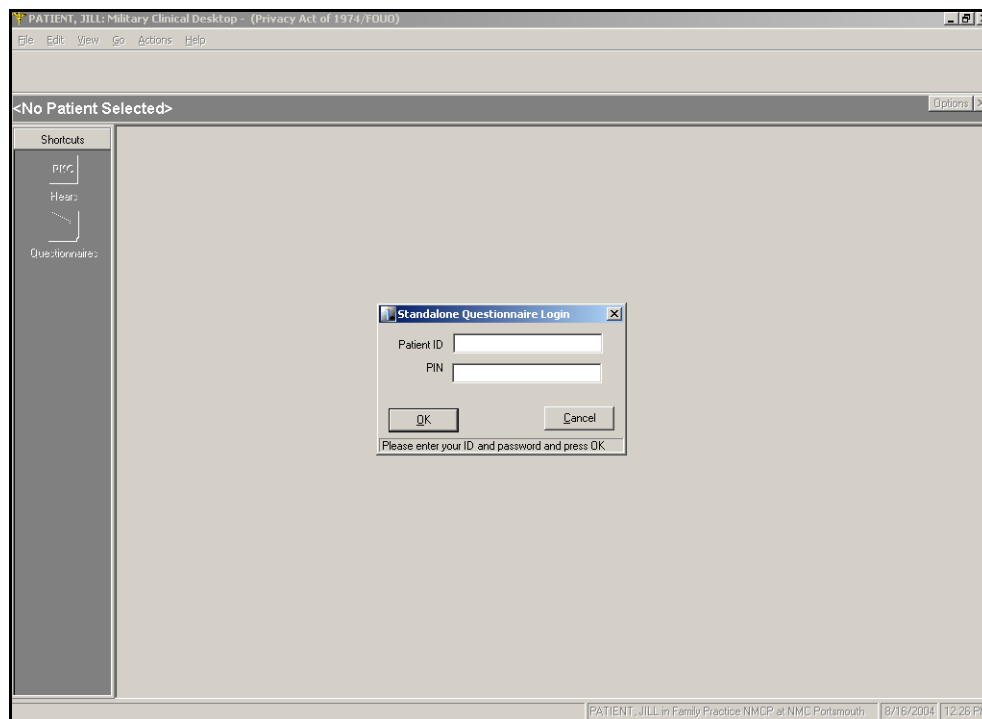


Figure 26-3: Kiosk and Login

4. The patients then proceed to the kiosk to answer the questionnaire. Patients select **Questionnaire** from the folder list and the login window opens, prompting them to enter their Patient ID and PIN.
5. Patients enter the requested information and click **OK**.
6. Patients then answer the questions that appear on screen.

Diabetes Self-Management Initial			
Click here to add comment on Questionnaire as a whole.			
1.	Do you drink alcohol?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
2.	Do you use tobacco or tobacco products?	<input checked="" type="radio"/> Yes	<input type="radio"/> No
3.	Do you have low blood sugar reactions?	<input checked="" type="radio"/> Yes	<input type="radio"/> No
4.	Do you know what to do for a low blood glucose reaction?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
5.	Do you monitor your blood glucose?	<input checked="" type="radio"/> Yes	<input type="radio"/> No
6.	How many times per day do you check you blood sugar?	Answer: <input type="text" value="1"/>	
7.	Do you exercise?	Answer: <input type="text" value="yes"/>	
8.	Type of exercise?	<input checked="" type="radio"/> walk <input type="radio"/> run <input type="radio"/> bicycle <input type="radio"/> aerobics <input type="radio"/> swim <input type="radio"/> other	

Figure 26-4: Questions

7. When the questions have been answered, the patients click **Save** and then **Done** from the Action bar.

26.4 Reviewing a Completed Questionnaire

You and your patients can review and modify a completed questionnaire, as necessary, and assign it to an encounter.

Follow the steps below to review a completed questionnaire:

1. Under the Health History Questionnaire Folder, the provider sees a completed Questionnaire screen. The Status shows Complete.

Questionnaire/Test History				
Date	Questionnaire/Test	Source	Encounter	Status/Score
5/24/01 12:42:54 PM	Diabetes Self-Management Initial	Interview by CHCSII, PATIENT		Complete

The Status now shows Complete.

Figure 26-5: Completed Questionnaire

2. The questionnaire can be reviewed with the patient and you can make changes to the patient's answers, as needed. A correction notation appears on any answers that have been changed.

The screenshot shows the 'Diabetes Self-Management Initial' questionnaire. The left pane lists various questionnaires, and the main area displays the questionnaire form. Question 5, 'Do you know what to do for a low blood glucose reaction?', has a correction notation: 'Correction entered by CRUZ, NEDSMOM@25 May 2001 12:30 Answer changed from Yes to NO'. The form includes radio buttons for 'Yes' and 'No' for each question.

Figure 26-6: Correction Notation

3. You can link the questionnaire to an open encounter by clicking **Encounter** from the Action bar. All open encounters for that particular patient appear.
4. Select the desired encounter and click **OK**. Click **Cancel** to return to the current encounter.
5. Before you can view questionnaire data in the Encounter document, you must set the encounter summary properties. Click **Options** in the upper, right corner of the Patient Encounter module. The Encounter Summary Properties window opens.
6. In the Encounter Summary Properties window, select the **Questionnaires** checkbox.

7. Click **OK**.
8. Click **AutoCite** to refresh the current encounter. The Questionnaire information is displayed in the S/O section.

Click Autocite to refresh the screen.

Date: 01 May 2001 1501 EDT Status: Updating MTF: NMC PORTSMOUTH
 Primary Provider: TMSSC, FOUR Type: WALK IN Clinic: DERMATOLOGY NMCP
 AutoCite: Autocites Refreshed by PROVIDER, MARY @ 25 May 2001 1251 EDT

Problems
 DIABETES MELLITUS
 headache
 BLOOD VESSEL INJURY MULTIPLE HEAD AND NECK VESSELS

Medications

Medication Name	Status	Sig	Refills	Last Filled
METFORMIN (GLUCOPHAGE)-PO 1,000MG TAB	Active	T1 #100 RF3	3	02 May 2001

Allergies
 Penicillins

Screening
 Screening Written by TMSSC, FOUR @ 01 May 2001 1510 EDT

Appointment Reason For Visit: appointment

Selected Reason(s) For Visit:
 Diabetes Follow-up

Vitals
 BP: 190/80 , HR: 55, RR: 40, T: 102.5 F , HT: 69, WT: 350 lbs, BMI: 51.69, BSA: 2.62 square meters 5/1/2001 1504 EDT (TMSSC, FOUR)

S/O
 Questionnaire Autocites Refreshed by PROVIDER, MARY @ 25 May 2001 1251 EDT

Questionnaire
 Diabetes Self-Management Initial Completed On: 24 May 2001

1. Do you drink alcohol?:
2. Do you use tobacco or tobacco products?: Yes
3. Do you have low blood sugar reactions?: No
4. Do you know what to do for a low blood glucose reaction?:
5. Do you monitor your blood glucose?: Yes
6. How many times per day do you check your blood sugar?: 1
7. Do you exercise?: Yes
8. Type of exercise?: walk

Questionnaire Data.

Figure 26-7: Questionnaire in Encounter

27.0 PATIENT SEARCH

27.1 Patient Search Overview

The Patient Search module allows a specific patient record to be selected. Once a patient name is selected, patient-specific functions are available. These modules are visible in the Go pull-down menu, the Shortcuts, the Folder list, and the Tool bar.

This search locates patient records that have been pulled into the CDR from CHCS. When scheduled appointments are made, patient information is loaded into the CDR via the nightly processes.

27.2 Conducting a Search

In order to do any work with a specific patient's record, a patient search must be conducted.

Follow the steps below to conduct a search:

1. On the Folder List, click **Search**. The Patient Search window opens.

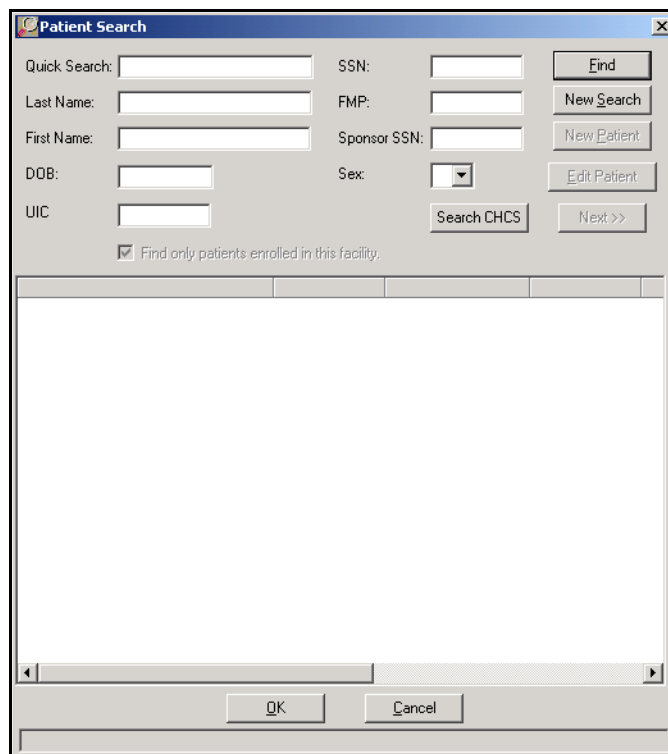


Figure 27-1: Patient Search Window

2. Enter search criteria into the appropriate field(s).

- **Quick Search:** The Quick Search function allows a patient to be selected using the following criteria:
 - L1234: Performs a search using the first letter of the last name and last 4 digits of the sponsor's SSN
 - L/1234: Performs a search using the first letter of the last name and last 4 digits of the patient's SSN
 - 20/123456789: FMP/Sponsor SSN
- **Last Name:** Performs a search using the patient's last name (use any combination of upper and lower-case).
- **First Name:** Performs a search using the patient's first name (use any combination of upper and lower-case).
- **DOB:** Performs a search using the patient's date of birth (use the format mm/dd/yyyy). The search returns all patients who were born in a four-year range from two years before the date to two years after the date.
- **UIC:** Performs a search using the location of the patient's/sponsor's unit command.
- **SSN:** Performs a search using the patient's Social Security Number.
- **FMP:** Performs a search using the Family Member Prefix.
- **Sponsor SSN:** Performs a search using the sponsor's Social Security Number.
- **Sex:** Performs a search using the patient's gender (choose a value from the list).

Note: The value B (for Both) doesn't make the program search regardless of gender. Rather, it indicates a search for the patients with a gender value of B, indicating that they are both male and female. U is for unknown (identifying remains).

- **Find only patients enrolled in this facility:** Click the checkbox to narrow the list of patients returned to only those patients enrolled in the current facility.

3. Click **Find** to view all patients who meet the selected criteria.

Note: When searching CHCS II, if the number of patients meeting the criteria exceeds 50, a prompt is shown asking to continue the search. Click **Yes** to continue or **No** to end the search and display the first 50 matches.

4. Select the patient from the list of results.

Tip:
When searching CHCS II, if the number of patients meeting the criteria exceeds 50, a prompt is shown, asking to continue the search. Click **Yes** to continue or **No** to end the search and display the first 50 matches.

- Click **OK**. The record opens in the Folder List with all available options.

Note: In the case of a patient who has not been seen in CHCS II, their records do not yet exist in the CDR. To locate the records, you must enter the search criteria and click **Search CHCS**.



Figure 27–2: Selected Patient’s Record in the Folder List

27.3 Selecting a Patient Record Without a Search

CHCS II retains the last 20 patient records that were viewed. Patient records can be selected from the list instead of performing a patient search.

Follow the steps below to select a patient without a search:

- On the **Go** menu, scroll to **Patient**.
- Select the desired patient from the list of recently viewed patient records.

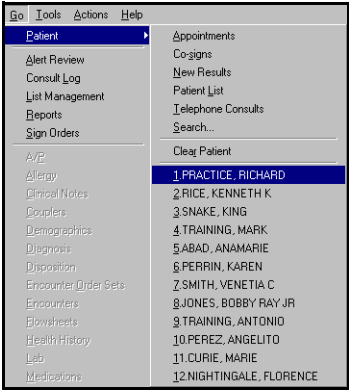


Figure 27–3: Select Patient Using the Go Drop-down Menu

28.0 PKC COUPLERS

28.1 PKC Couplers Overview

The questionnaires associated with the Problem Knowledge Couplers, Inc. (PKC) Couplers module automate the collection of demographic and health data for patients. The questionnaires provide the clinical team member a “snapshot” of the patient's health, habits and other factors that can affect his/her overall health. The data is then used to assess preventive service needs, identify services routinely used, and determine the appropriate level of medical expertise/care required for each patient. PKC Couplers are patient-specific, so a patient's record must be loaded to the Military Clinical Desktop before the PKC Couplers module is available.

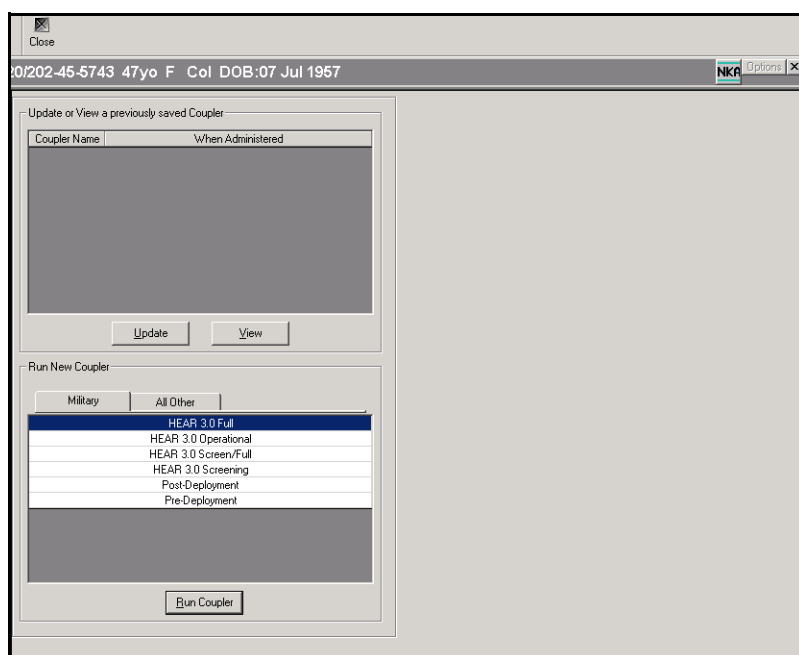


Figure 28–1: PKC Couplers Module

28.1.1 In More Depth

The functions available upon accessing the PKC Couplers module depends on security access roles. A user, with the role of ward_clerk is permitted to generate and print a patient password to be used by the patient to access the HEAR questionnaire at a kiosk. The majority of other users are permitted to display, run, and update completed questionnaires.

28.2 Running a New Coupler

Two types of questionnaires can be administered: Military and All Others.

Follow the steps below to run a new coupler:

1. On the Couplers module, click either the **Military** or **All Others** tab.

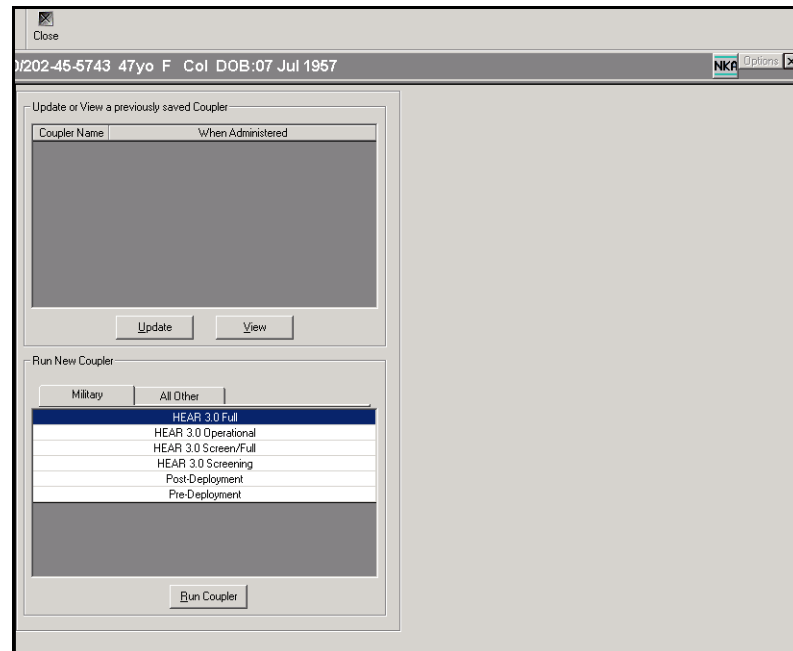


Figure 28–2: Military and All Others Tabs

2. Select the desired questionnaire.
3. Click **Run Coupler** to access the PKC Couplers application.

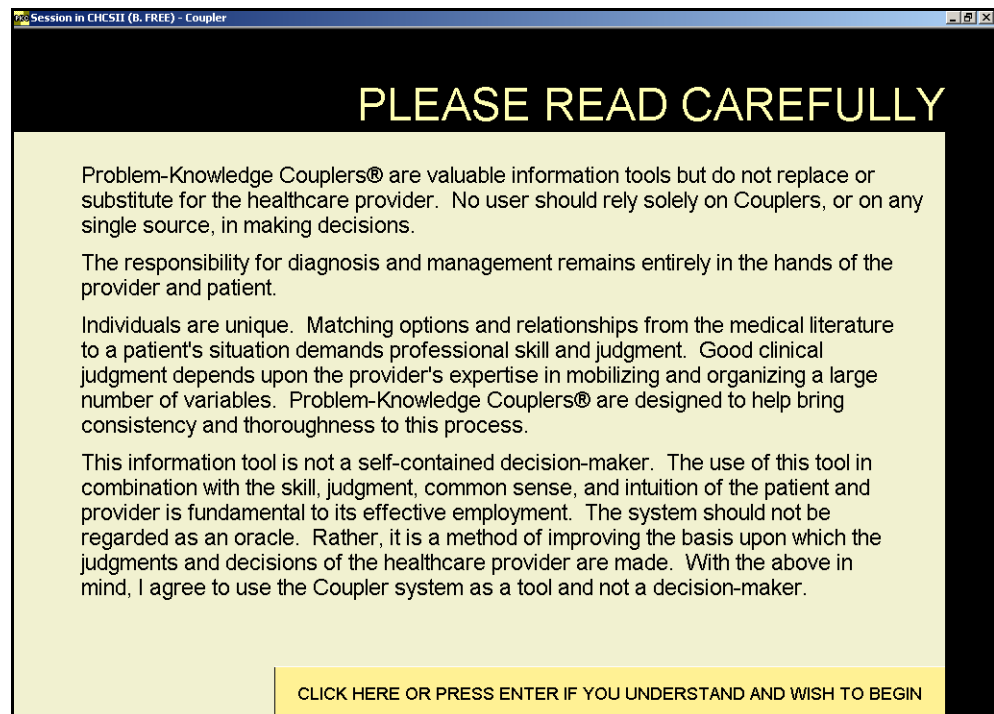


Figure 28–3: PKC Couplers Application

4. Read the medical disclosure statement and press **Enter** on your keyboard to indicate understanding of the statement.

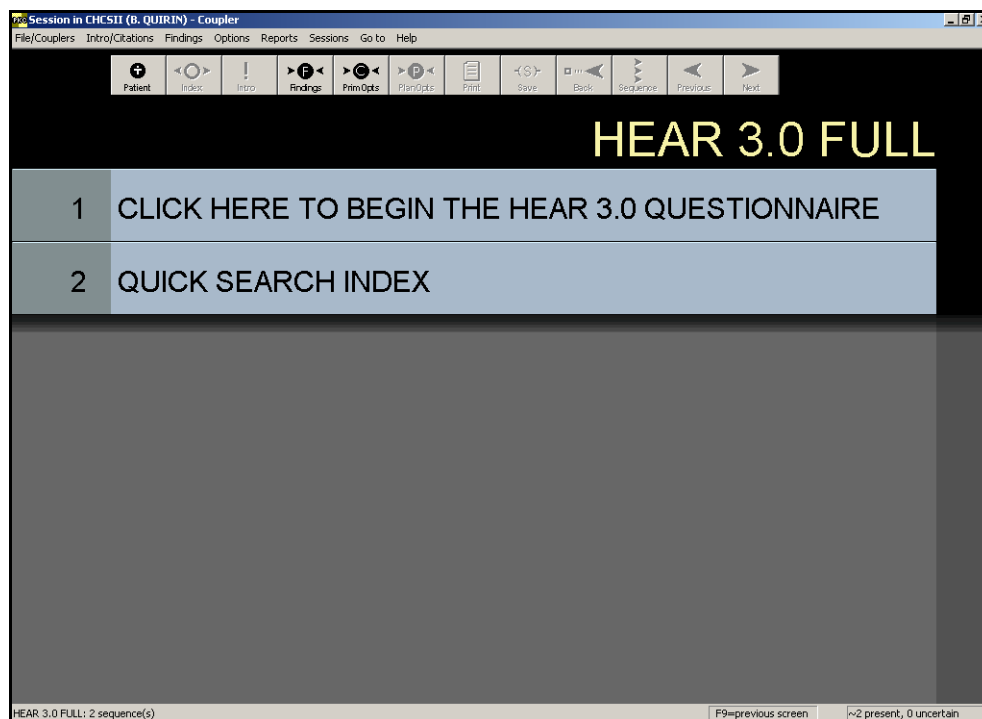


Figure 28-4: PKC Couplers Application

5. Do one of the following:
 - If the questionnaire is from the Military tab, the questionnaire begins with an opening sequence that presents options for running the questionnaire. To start the questionnaire:
 - a. Click **Click Here to Begin the HEAR 3.0 Questionnaire**.
 - b. Answer the survey questions.

Note: If answers are missing or are invalid, an error message appears. To correct the error, click **Yes**; click **No** to continue.

- If the questionnaire is from the All Others tab, the system begins with an overview of the subject areas presented in the questionnaire. To start the questionnaire:
 - a. Click the applicable area.
 - b. Select a response to answer a question. Click twice to mark a question as uncertain. Click a third time to clear the question.
 - c. On the toolbar, click the **Next Arrow** button to move to the next window to respond to the next question.

6. At the end of the questionnaire, on the File/Couplers menu, click **Exit & Return to CHCS II**.
7. Click **Yes** to save the findings and exit the questionnaire.

28.3 Viewing a Completed Coupler

The Coupler module displays completed questionnaires and a list of questionnaires that can be administered. Each completed questionnaire can be viewed and updated.

Follow the steps below to view a completed coupler:

1. Select the desired questionnaire to be viewed on the Couplers module.

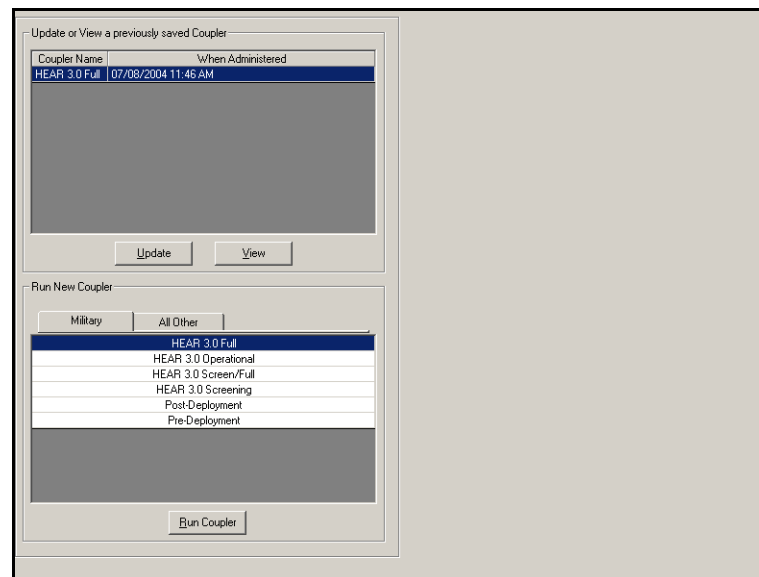


Figure 28–5: Couplers Module

2. Click **View**. The PKC application begins and the completed questionnaire is available to review.

28.4 Updating a Completed Coupler

Completed questionnaires can be updated if they have not been completed or if there are errors that need to be resolved.

Follow the steps below to update a completed coupler:

1. Select the questionnaire to be updated.
2. Click **Update**. The PKC application opens to the completed questionnaire.
3. Update the questionnaire.
4. Save the questionnaire.

- On the File/Couplers menu, click **Exit & Return to CHCS II**. The updated questionnaire is saved as a separate questionnaire. It does not replace the original questionnaire.

28.5 Using a Kiosk to Complete the HEAR Questionnaire

The HEAR questionnaire can be completed through a stand-alone kiosk. A Clinical Team Member generates a password for the patient to enter when using the kiosk. The password is linked to that specific patient and is active for 24 hours. The ability to access the Generate Password window is a separate role (ward_clerk) within CHCS II and must be assigned before performing the following tasks.

Follow the steps below to start the HEAR Questionnaire:

- Access the Coupler module. The Coupler Utility Application window opens.

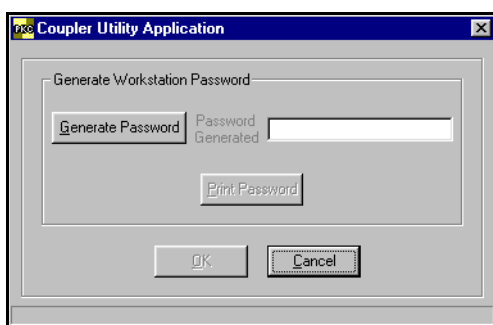


Figure 28-6: Coupler Utility Application Window

- Click **Generate Password** to create a password for the patient.
- Click **Print Password** to print the password for the patient.
- Direct the patient to the kiosk. The patient only has access to the Coupler module to complete the questionnaire.
- The patient clicks **PKC/HEAR** to view the HEAR Questionnaire Login window.

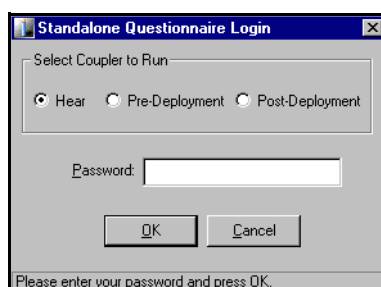


Figure 28-7: Kiosk Questionnaire Login Window

- The patient types the given password and clicks **OK** to launch the questionnaire.
- The system begins with an opening sequence that presents three options for running the questionnaire. Click **Begin Questionnaire** to start.

8. After answering a survey question, advance through screens in one of the following ways:
 - Select the box marked **Press <F10>** or **Click Here** to continue.
 - Press **<F10>**.
 - On the toolbar, click the **Next Arrow** button.

Note: Press **<F9>** or click **Previous** on the tool bar to see the previous screen.

- If answers are missing or are invalid, an error message appears. Click **Yes** to correct the error, **No** to continue.
-

9. At the end of questionnaire, click **Exit & Return to CHCS II** on File/Couplers on the menu bar.
10. Click **Yes** to save the findings and exit the questionnaire.
11. The patient informs the Clinical Team Member that the questionnaire is complete. The Clinical Team Member returns to the Coupler module and views the Coupler Utility Application window.
12. Enter the name of the stand-alone workstation in the **Workstation Name** field.
13. Click **Import to CDR** to import the results. When a Clinical Team Member views the Coupler module, the imported questionnaire is available for review.

28.6 Finding Summary Report

This option allows the proctor or provider to access and review the Finding Summary report, which displays the patient's responses under specific headings, after the questionnaire is completed in the PKC application.

Follow the steps below to find the summary report:

1. On the Findings menu, click **Finding Summary**. The Finding Summary report opens.

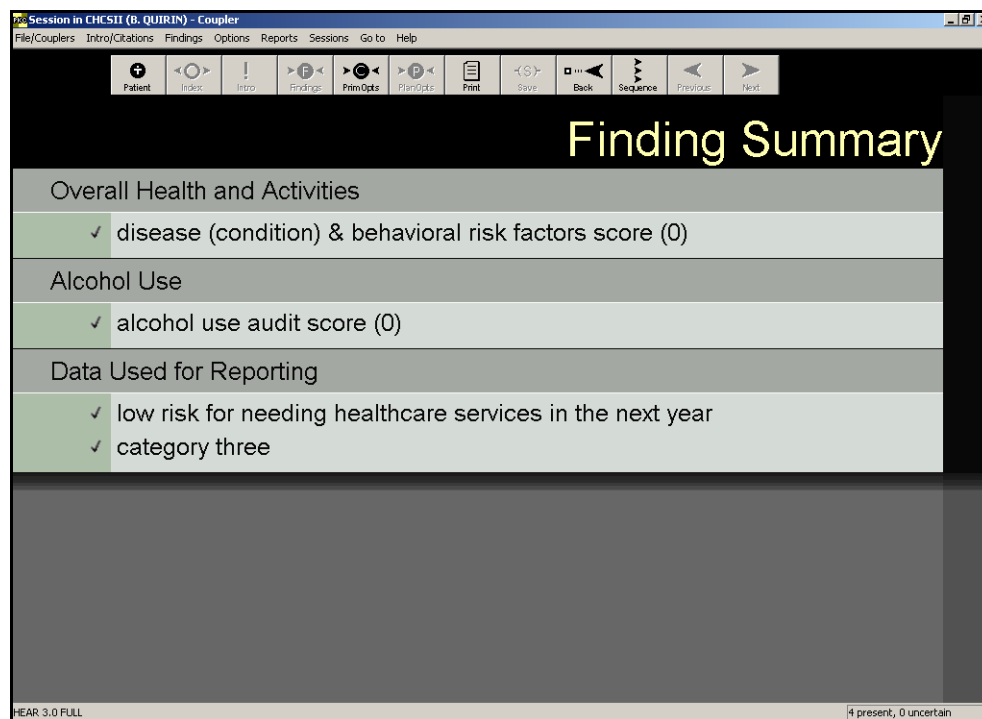


Figure 28–8: Couplers Finding Summary Report

2. View the answers that the patient entered. A checkmark indicates that the question has been answered, a question mark indicates an uncertain answer.
3. Double-click an uncertain finding to return to the question in order to answer it completely and correctly.

28.7 Reviewing and Resolving the Finding Error Summary

This option allows the proctor or provider to access and review the Finding Error Summary Report. An error message is displayed whenever the rules of a question have been violated. The patient has the option of either correcting the error by answering the question, or moving forward without making the suggested corrections. All error messages that are not corrected are displayed in the Finding Error Summary Report. From this report, the error can be corrected.

Follow the steps below to review and resolve the finding error summary report:

1. When the questionnaire is completed, click **Finding Error Summary** on the Findings menu. The Finding Error Summary Report opens.

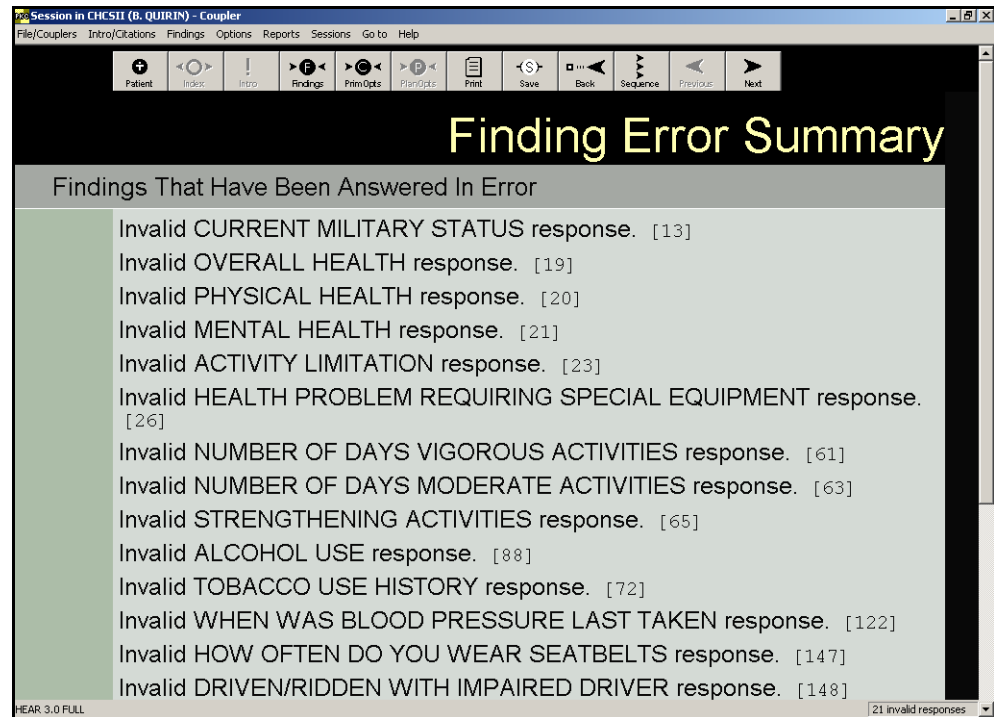


Figure 28–9: Couplers Finding Error Summary Report

2. To resolve any error messages:
 - a. At the end of the error message, click the number in brackets (e.g., [13]).
 - b. Correct the error.
 - c. Repeat steps until all error messages are resolved.
3. At the end of questionnaire, click **File/Couplers** on the menu bar.
4. Click **Exit**.
5. Click **Yes** to save findings and exit the questionnaire.

28.8 Printing or Previewing a Report

Follow the steps below to print or preview a report:

1. Access the Reports pull-down menu and select **Print Any Reports** to view the Print Any Reports window.
2. Select the report to be printed by clicking in the check box next to the desired report.
3. Enter a *Report Comment* if necessary. If the comment needs to be saved, click **Save as Session Comment**.
4. Select necessary **Details for Primary Options** to be printed if Details for Primary Options is selected. Highlight the desired **Primary Options for Plan Option** if Primary Option Index is selected.

5. Click **OK** to print.
6. Click **Reset** to clear any changes made to the form.

29.0 PREVIOUS ENCOUNTERS

29.1 Previous Encounters Overview

The Previous Encounters module displays a list of a patient's completed CHCS II encounters. Select a previous encounter to view the signed electronic SF600 in the bottom of the workspace. You must select a patient record to view previous encounters. You can append a narrative, amend an encounter, create a new Encounter Template from a completed encounter and “copy forward” the details of a previous encounter to the current encounter, easing effort and saving time in documenting follow-up visits.

The Previous Encounters module defaults to display the last four previous encounters for a patient. If you want to view all previous encounters for a patient, select the **View All** radio button.

Date	Status	Primary Diagnosis	Clinic
20 Jan 2003 1141	Updated	UPPER RESPIRATORY INFECTION	MTF NMCP FP
18 Nov 2002 0925	Complete	UPPER RESPIRATORY INFECTION	MTF NMCP FP
05 Nov 2002 0934	Complete	SINUSITIS	MTF NMCP FP
25 Oct 2002 1359	Updated	SINUSITIS	MTF NMCP FP

Signed Encounter Documents: 20 Jan 2003 1156 signed by DOCTOR, GARY (2 documents found)

Patient: TRAINING, MARK Date: 20 Jan 2003 1141 EST Appt Type: WI
Facility: NMC Portsmouth Clinic: MTF NMCP FP Provider: DOCTOR, GARY

Reason for Appointment:
URI

Appointment Comments:
Notes Entered by: DOCTOR, GARY @ 20 Jan 2003 1141
Same old stuff

AutoCites Refreshed by DOCTOR, GARY @ 20 Jan 2003 1142 EST

Allergies
Penicillins
OTHER Class

Screening Written by DOCTOR, GARY @ 20 Jan 2003 1150 EST

Appointment Reason For Visit: URI

Allergen information verified by DOCTOR, GARY @ 20 Jan 2003 1150 EST

Selected Reason(s) For Visit:
UPPER RESPIRATORY INFECTION (Follow-Up) Comments:

Vitals

Figure 29-1: Military Clinical Desktop—Previous Encounters Module

29.2 Appending a Narrative

The Append Narrative function enables you to attach text or a graphic file to a completed encounter. Graphics that are imported cannot be greater than 500K. The narrative appears at the bottom of the encounter, stamped with the time, date, and author's name. Since the narrative is added after the encounter was signed, the note itself must be signed by the author.

Follow the steps below to append a narrative:

1. Select an encounter.
2. Click **Append Narrative** on the Action bar. The Encounter Note window opens.

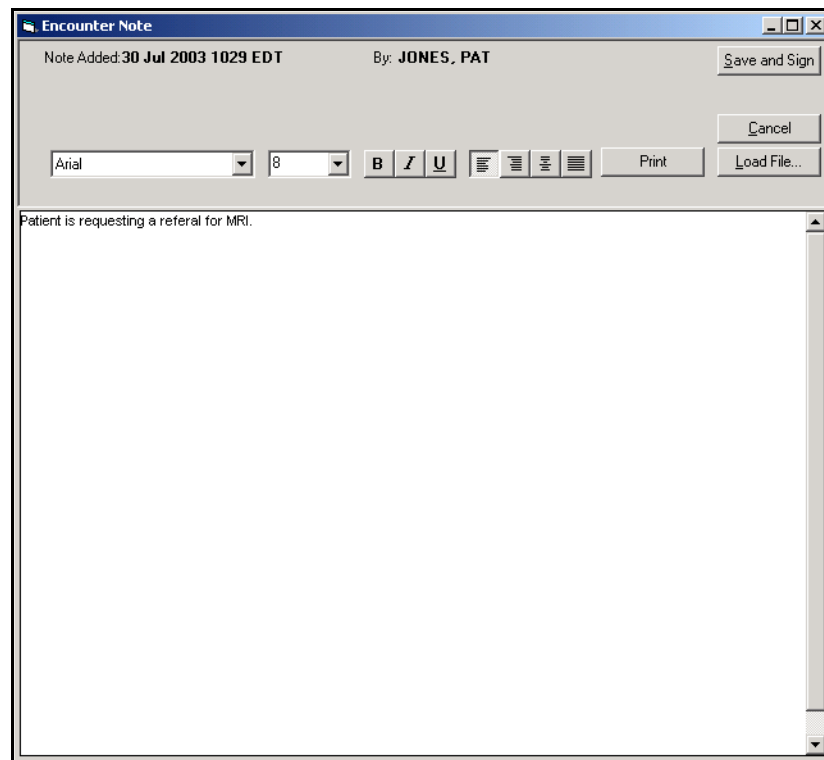


Figure 29-2: Encounter Note Window

Tip:

Copied text can be pasted directly into the text box.

3. Enter a note category, if appropriate.
4. Enter a note title, if appropriate.
5. Enter the note in the text box.
6. Do one of the following:
 - If you want to insert a file into the note:
 - a. Click **Load File**. The Select Destination File window opens.

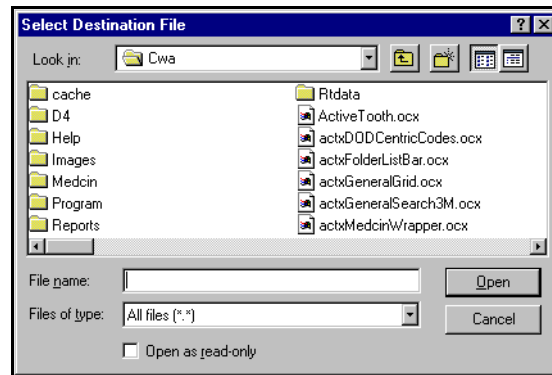


Figure 29-3: Select Destination File Window

- b. Select the file to be added.
- c. Click **Open**. The contents of the file are displayed in the text box.

Note: Graphics that are imported must be 500K or less.

- If you want to print the note for your hardcopy records, click **Print**.
7. Click **Save and Sign**. The Sign Appended Note window opens, so you can review the narrative before signing.

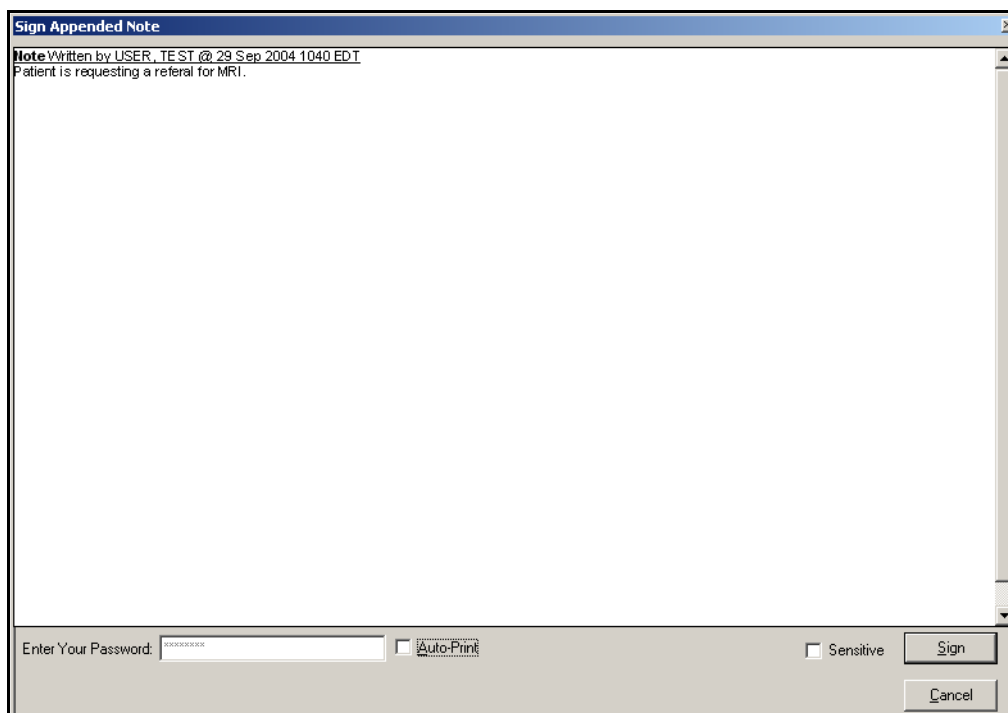


Figure 29-4: Sign Appended Note Window

8. Enter your password and click **Sign**. The narrative appears at the bottom of the encounter summary with the Time, Date, and your name next to the narration.

29.3 Amending a Previous Encounter

Amending an encounter allows original information to be changed by the original provider or the provider's supervisor. The amended encounter document must be signed. When you sign an amended encounter, the amended information is sent to ADM to update the original information.

Follow the steps below to amend an encounter:

1. Select the previous encounter you want to amend.
2. Click **Amend Encounter** on the Action bar. The Patient Encounter module opens for the selected encounter.

The screenshot displays the Patient Encounter module interface. At the top, it shows the date (27 Sep 2004 1740 EDT), status (Needs Co-Signature), and primary provider (DOCTOR, DAVID). Below this, the 'Reason for Appointment' section is active, showing 'AutoCites Refreshed by @ 27 Sep 2004 1713 EDT'. The 'Problems' section lists 'OTITIS MEDIA ACUTE SEROUS'. The 'Active Dispensed Medications' table shows 'NEOSYNEPHRINE NASAL 0.25%-NAS 0.125MG/G' with a status of 'Active' and a signature of '1-2 DROPS EACH NOSTRIL Q12HR'. The 'Allergies' section lists 'Sulfa-Drugs'. The 'Screening' section shows 'Screening Written by DOCTOR, DAVID @ 27 Sep 2004 1713 EDT'. The 'Appointment Reason For Visit' is 'Earache'. The 'Allergen information verified by DOCTOR, DAVID @ 27 Sep 2004' section shows 'Selected Reason(s) For Visit: earache (New) Comments:'. The 'Vitals' section shows 'Vitals Written by DOCTOR, DAVID @ 27 Sep 2004' with HR: 90, RR: 16, T: 100.1 °F, WT: 12 kg. The 'S/O' section shows 'SO Note Written by DOCTOR, DAVID @ 27 Sep 2004 1740 EDT'. The 'Chief complaint' is 'The Chief Complaint is: Earache.' The 'History of present illness' describes a 2-year 3-month-old female with a fever of 102.2 axillary, treated with Motrin, and earache in the right ear for 3 days. The 'Past medical/surgical history' lists 'Otitis media age 18m'. The 'Personal history' notes 'Family: The child is enrolled in day-care.'

Figure 29–5: Encounter Summary

3. Update applicable sections of the encounter.
4. Once the changes have been made, the amended encounter document must be signed. Click **Sign** on the Action bar. The Sign Encounter window opens.

Sign Encounter		
Patient: ALEX, E D	Date: 09 Mar 2004 0953 EST	Appt Type: ACUT
Facility: 4th Medical Group	Clinic: Silver MTF	Provider: SMITH, JACOB
Patient Status: Outpatient		
Reason for Appointment: uri		
AutoCites Refreshed by SMITH, JACOB @ 09 Mar 2004 0955 EST		
Problems • ACHILLES TENDON ADHESIONS LEFT LEG • visit for: neonatal observ for suspect neurologic condition • CONJUNCTIVITIS - BOTH EYES • DIABETES MELLITUS • ACUTE POST-TRAUMATIC STRESS DISORDER		Allergies • PENETRATING RELIEF (MENTHOL): Rash
Active Medications No Active Medications Found.		
Screening Written by SMITH, JACOB @ 09 Mar 2004 0954 EST		
Reason For Appointment: uri		
Reason(s) For Visit (Chief Complaint): UPPER RESPIRATORY INFECTION (New);		
Vitals Written by SMITH, JACOB @ 09 Mar 2004 0956 EST BP: 130/70		
SO Note Written by SMITH, JACOB @ 09 Mar 2004 0956 EST		
History of present illness The Patient is a 54 year old male. • Nasal discharge. • Feeling congested in the chest and wheezing.		
Past medical/surgical history		
Enter Your Password: <input type="password"/>	<input checked="" type="checkbox"/> Auto-Print	<input type="checkbox"/> Sensitive <input type="button" value="Sign"/>
<input type="checkbox"/> Cosigner Required <input type="password"/>	<input type="button" value="Search"/>	<input type="button" value="Cancel"/>

Figure 29–6: Sign Encounter Window

5. In the **Enter Your Password** field, enter your password.
 - If you do not want to Auto-Print the signed encounter, click the **Auto-Print** checkbox to deselect this option.
 - If a co-signer is required, select the **Cosigner Required** checkbox.
 - If you want to mark the amended encounter as sensitive, select the **Sensitive** checkbox. Sensitive data is displayed with asterisks. Providers other than the primary and co-signing must have “break the glass” privileges to view the sensitive data.
6. Click **Sign** to sign the encounter. The Change History section of the encounter is documented with the amendments.

Disposition	Disposition Written by PROVIDER, DYLAN @ 02 Jul 2001 1429 EDT Released Without Limitations E&M Code: 99212: Estab Outpatient Focused H&P - Straightforward Decisions
AddNote	
Change History	CHANGE HISTORY <i>The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by PROVIDER, DYLAN @ 18 Jul 2001 1115 EDT.</i> Signed@ 02 Jul 2001 1429 PROVIDER, DYLAN Physician NMC PORTSMOUTH <i>The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by PROVIDER, DYLAN @ 18 Jul 2001 1124 EDT.</i> Signed@ 18 Jul 2001 1124 PROVIDER, DYLAN Physician NMC PORTSMOUTH

Figure 29–7: Change History Section of an Encounter

29.4 Creating a New Encounter Template

After you document an encounter, you can use the structure of the previous encounter to create a new encounter template. No patient-specific information is saved in the encounter template.

Follow the steps below to create a new encounter template:

1. Click **New Template** on the Action bar. The Template Management module opens with details populated in the Template Details tab.

The screenshot displays the 'Template Details' tab of the Template Management module. The form is organized into several sections, each with 'Add' and 'Remove' buttons:

- Template Name:** Created from Encounter 105950
- Owner Type:** Personal (dropdown)
- User:** JONES, PAT (dropdown)
- Specialty:** (dropdown)
- EM Code Category:** (dropdown)
- Associated Reasons for Visit:** nasal discharge, a cough 786.2
- Associated Problems:** ACUTE BRONCHITIS 466.0
- Diagnoses:** ACUTE BRONCHITIS 466.0
- Notes Templates:** (List) Created from Encounter 105950
- Other Therapies:** Oral Fluids, Return To Clinic If Worse Or New Symptoms
- Associated Appointment Types:** w/
- Items to Autocite into Note:**
- Procedures:** Pulmonary Function Tests Peak Flow 94150
- Orders:** (Med)ALBUTEROL ORAL (PROVENTIL)-INH 90MCG AE, (Lab)CBC w/AUTO DIFF

Figure 29–8: Template Management module—Template Details Tab

2. Add or remove information from the following areas:
 - **Associated Reasons for Visit, Associated Problems, Associated Appointment Types:** These three areas are rarely used within CHCS II. These areas

determine those templates that the system suggests when you go to load a template.

- **Items to AutoCite into Note:**
 - Click **Add**.
 - Select an AutoCite selection from the list and click **Add Items**.
 - Click **Done** to return to the Template Details tab.
- **Diagnoses, Other Therapies, Procedures:**
 - Click **Add** next to the appropriate section.
 - In the **Search Term** field, enter the first few letters of the procedure and click **Search**.
 - Select the item from the search results and click **Add Items**.
 - Click **Done** to return to the Template Details tab.
- **Notes Templates:**
 - Click **Add**.
 - Click **Search** to open the List Note Template Search window.
 - Enter search criteria in the window and click **Search**.
 - Select the note template and click **Add Items**.
 - Click **Done** to return to the Template Details tab.

3. Click **Save As** on the Action bar. The Save Encounter Template window opens.

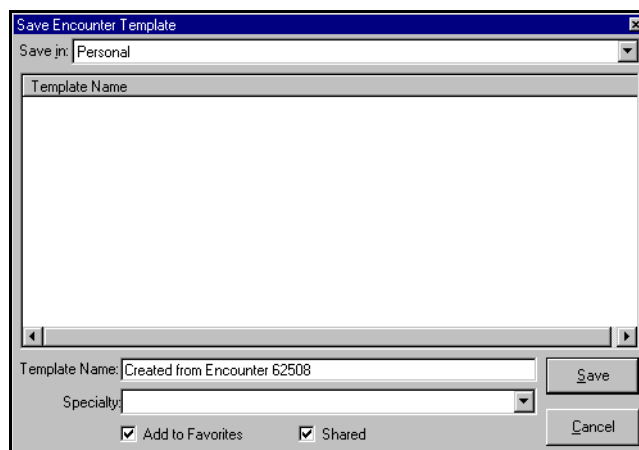


Figure 29–9: Save Encounter Template Window

4. Select the **template type** from the Save-in drop-down list.
5. In the **Template Name** field, enter the template name.
6. Select the **Specialty** from the drop-down list.
7. Click the checkboxes to denote whether the template should be added to your Favorites List or shared with other Clinical Team Members.

8. Click **Save**.

29.5 Copy Forward

Users can “Copy Forward” a previous encounter document for use in the current encounter. This enables you to quickly and efficiently copy work from previous encounter(s) to the current encounter. This feature saves charting steps for a follow-up visit or if the patient has many complicated problems. The diagnoses, orders, procedures, and other therapies of the previous encounter will copy forward as if it were an Encounter Template.

Follow the steps below to Copy Forward a previous encounter:

1. With a current encounter open, click **Previous Encounters** in the Folder List. The Previous Encounter module opens.

Date	Status	Primary Diagnosis	Clinic
22 Jan 2003 1446	Updated	UPPER RESPIRATORY INFECTION	MTF NMCP FP
26 Nov 2002 1353	Complete		Dental NMCP
26 Nov 2002 1341	Complete	reason for visit: single organ system exam dental	Dental NMCP
26 Nov 2002 1246	Complete	reason for visit: single organ system exam dental	Dental NMCP

Signed Encounter Documents: 23 Jan 2003 0900 signed by DOCTOR, GARY (3 documents found)

Patient: RICE, KENNETH K Date: 22 Jan 2003 1446 EST Appt Type: WI
 Facility: NMC Portsmouth Clinic: MTF NMCP FP Provider: DOCTOR, GARY

Reason for Appointment:
 URI

Appointment Comments:
 Notes Entered by: DOCTOR, GARY 22 Jan 2003 1446
 Pt reports frequent URI

AutoCites Refreshed by DOCTOR, GARY @ 22 Jan 2003 1448 EST

Allergies
 ASPIRIN (ASPIRIN)

Screening Written by DOCTOR, GARY @ 22 Jan 2003 1448 EST

Appointment Reason For Visit: URI

Selected Reason(s) For Visit:
 UPPER RESPIRATORY INFECTION (New) Comments:

Vitals
 Vitals Written by DOCTOR, GARY @ 22 Jan 2003 1448 EST
 BP: 128/80, HR: 75, T: 100.1 °F, HT: 5' 11", WT: 200 lbs, PF: 50S, BMI: 27.89, BSA: 2.109 square meters

Figure 29–10: Previous Encounter Module

2. Select the previous encounter to copy forward.
3. Click **Copy Forward** on the Action bar. You are returned to the current encounter.

Figure 29–11: Current Encounter Summary

- Click **S/O**. The S/O module opens.

Figure 29–12: Copy Forward Items Highlighted

Note: Items copied forward are marked in yellow. Click the copied forward items to insert them into the current encounter note. Click **AutoEnter** on the S/O dashboard to insert all items copied forward.

- After completing the S/O module, click **A/P**.

Note: To view the diagnoses, procedures, order sets or other therapies, open the template drop-down and select <Copy Forward Template>. The A/P information associated with the previous encounter will display on the appropriate tabs. Once the copy forward template is loaded, you can document the encounter as if you were using any other encounter template.

29.6 Printing Previous Encounter Documents

Tip:

To print multiple encounters, press the **Ctrl** key on your keyboard and select each encounter.

Follow the steps below to print selected previous encounters:

1. Select the previous encounter you want to print.
2. Click **File** on the Menu bar, scroll over **Print** and select **SF600**. The Print window opens.
3. Select the Print Range and click **OK**. The SF600 will print to the default printer associated with your workstation.

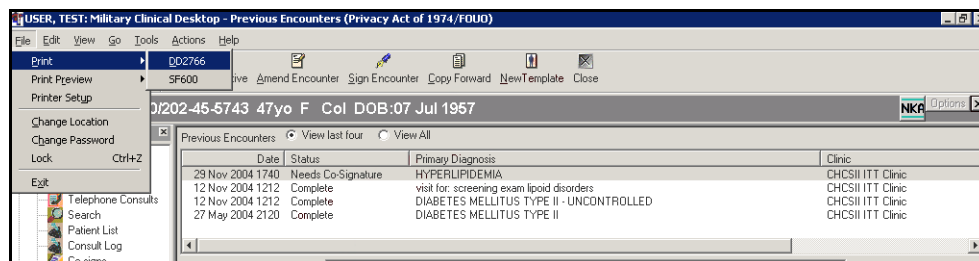


Figure 29–13: Print Previous Encounter

30.0 PROBLEMS

30.1 Problems Overview

The Problems module displays a problem list, Healthcare maintenance, Dental Readiness Classification, Historical Procedures, and Family History information for the selected patient in the top portion. Dental Readiness Classification information is populated by the Dental module and is read only. Problems (diagnoses) and Family History data added during an encounter automatically update the Problems module when the encounter is signed.

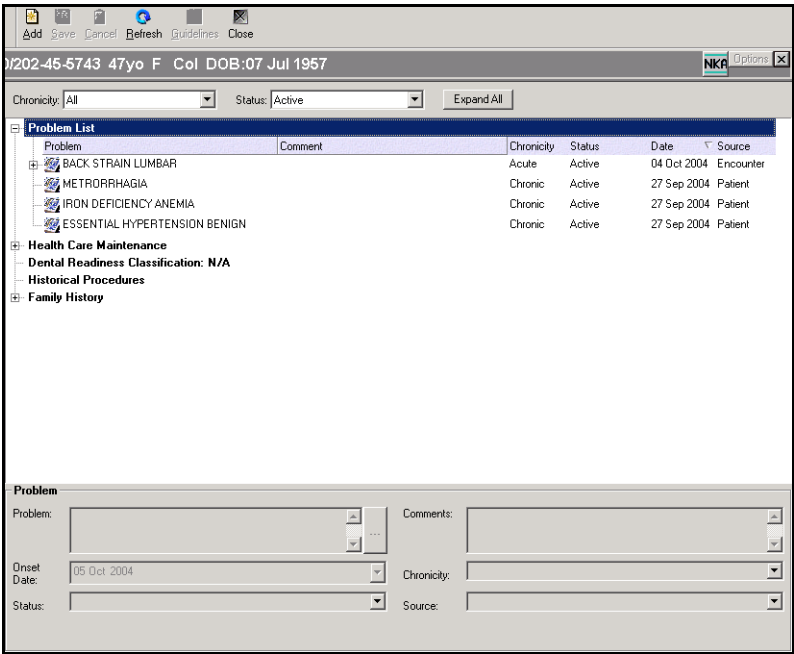


Figure 30–1: Military Clinical Desktop—Problems Module

30.2 Viewing the Problem List

Use the two filter options to view selected problems on the list. The two filter criteria are Chronicity and Status.

Follow the steps below to view the problem list:

1. Select a **Chronicity** filter from the drop-down list. The default is Chronic.
2. Select a **Status** filter from the drop-down list. The default is Active.

Tip:
Click the *Expand All* checkbox to view the associated encounters and orders for all problems.

Note: Details about any associated encounters, procedures, medications, labs, and radiology procedures associated with the selected problem can be displayed by clicking the plus sign to the left of the item. Double-click the associated encounter to view the encounter details in the Previous Encounter module.

Double-click the radiology or lab results to view the details in the respective modules.

30.3 Adding a Problem

New problems are automatically added to the problem list every time an encounter is signed. The diagnosis from each encounter becomes a problem. Use the following procedure to add a problem that was not documented through an encounter.

Follow the steps below to add a problem:

1. Select the **Problem List** header.
2. Click **Add** on the Action bar. The Select Diagnosis window opens.

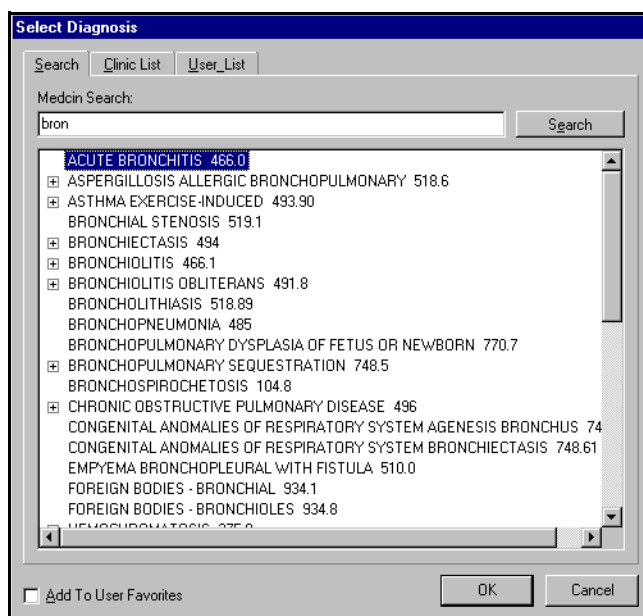


Figure 30-2: Problems—Select Diagnosis Window

3. Select the diagnosis you want to add. The selected problem appears in the New Problem pane on the Problems module.

Note: The Select Diagnosis window contains three tabs:

- **Search:** Click the Search tab and enter the first few letters of the diagnosis in the **MEDCIN Search** field and click **Search**. Select the diagnosis and click **OK**.
- **Clinic List:** Click the Clinic List tab and enter the first few letters of the diagnosis in the **Find** field and click **Find**. Select the diagnosis from the Clinic List results and click **OK**.

- **User List:** Click the User List tab and enter the first few letters of the diagnosis in the **Find** field and click **Find**. Select the diagnosis from the **User List** results and click **OK**.

Note: If the Add to Favorites checkbox is selected, the selected diagnosis and ICD-9 code are added to your list of favorite diagnoses in the List Management module. All diagnoses in that list are available in the User List tab of the Problems module. You cannot change the items in the Clinic List tab.

Figure 30-3: New Problem Pane

- Complete the appropriate fields.
 - **Onset Date:** Click the drop-down arrow to select the correct date the problem began.
 - **Chronicity:** Select **Acute** or **Chronic** from the drop-down list.
 - **Status:** Select **Active**, **Deleted (Error)**, or **Inactive** from the drop-down list.
 - **Comments:** Add a note for a selected problem or procedure.
 - **Source:** The manner in which you received the problem information:
 - Patient
 - Encounter
 - HEAR
- Click **Save** on the Action bar.

30.4 Adding an Historical Procedure

Historical procedures can be followed as problems. These procedures are not automatically populated from the A/P module when an encounter is signed, in the way diagnoses are. The procedures are added directly from the Problems module.

Follow the steps below to add an historical procedure:

- Click the **Historical Procedures** header.
- Click **Add** on the Action bar. The Select Procedure window opens.

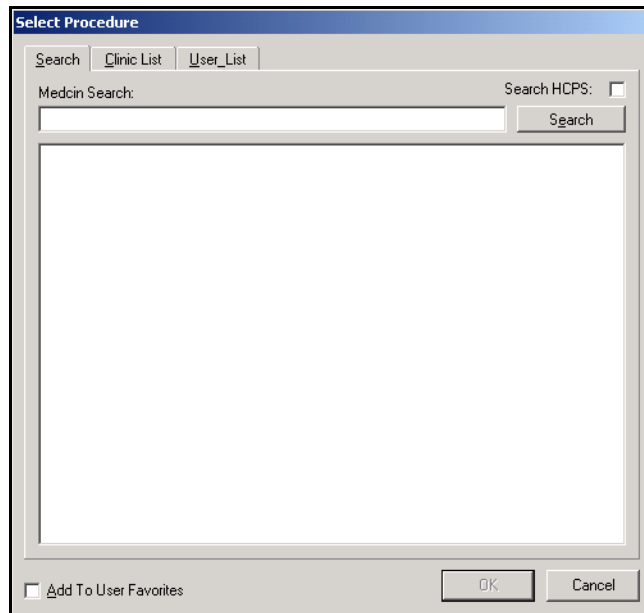


Figure 30-4: Problems—Select Procedure Window

3. Select the procedure you want to add. The selected procedure displays in the New Procedure pane on the Problems module.

Note: The Select Procedure window contains three tabs:

- **Search:** Click the Search tab and enter the first few letters of the procedure in the **MEDCIN Search** field and click **Search**. Select the procedure and click **OK**.
 - **Clinic List:** Click the Clinic List tab and enter the first few letters of the procedure in the **Find** field and click **Find**. Select the procedure from the Clinic List results and click **OK**.
 - **User List:** Click the User List tab and enter the first few letters of the procedure in the **Find** field and click **Find**. Select the procedure from the **User List** results and click **OK**.
-

Note: If the **Add to Favorites** checkbox is checked, the selected Procedure and CPT-4 codes are added to your list of favorite diagnoses in the List Management module. All diagnoses in that list are available in the User List tab of the Problems module. The items in the clinic list cannot be changed by the user.

Figure 30-5: New Procedure Pane

4. Complete the appropriate fields:
 - **Procedure Date:** Click the drop-down arrow to select the date the procedure was performed.
 - **Status:** Select **Active**, **Deleted (Error)**, or **Inactive** from the drop-down list.
 - **Comments:** Add a note for a selected problem or procedure.
5. Click **Save** on the Action bar.

30.5 Adding Family History Problems

The Problems module allows you to document specific problems in a patient's family history. Positive and negative family history documentation from the S/O module is displayed in the Family History area in the Problems module.

Follow the steps below to add family history problems:

1. Select the **Family History** header.
2. Click **Add** on the Action bar. The Select Diagnosis window opens.
3. Select the diagnosis you want to add. The selected problem appears in the New Family History pane on the Problems module.

Figure 30-6: New Family History Pane

4. Complete the appropriate fields:
 - **Onset Date:** Click the drop-down arrow to select the date of the onset of the problem.
 - **Status:** Select **Active**, **Deleted (Error)**, or **Inactive** from the drop-down list.
 - **Sensitivity:** Click the checkbox to mark the family history problem as sensitive.
 - **Comments:** Add a note for the family history problem.
 - **Relationship:** Select the family member from the drop-down list.

- **Source:** The manner in which you received the family past medical history problem.

5. Click **Save** on the Action bar.

30.6 Updating a Problem or Procedure

Problems and procedures can be updated from the Problem List, Historical Procedures, and Family History areas.

Follow the steps below to update a problem or procedure:

1. Select a problem or procedure. The Update Problem or Procedure pane displays on the Problems module.

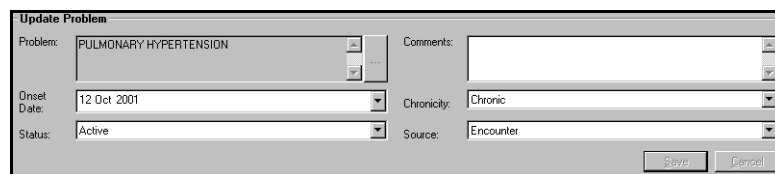


Figure 30–7: Update Problem Pane

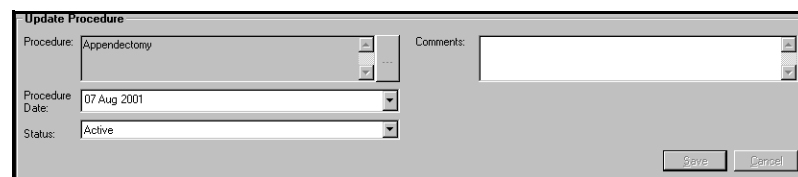


Figure 30–8: Update Procedure Pane

2. Do one of the following:
 - If you are updating a problem, update the following fields, as necessary:
 - Onset Date
 - Status
 - Comments
 - Chronicity
 - Source
 - If you are updating a procedure, update the following fields, as necessary:
 - Procedure Date
 - Status
 - Comments
 - If you are updating a patient's family history, update the following fields, as necessary:
 - Onset Date
 - Status

- Comments
- Relationship

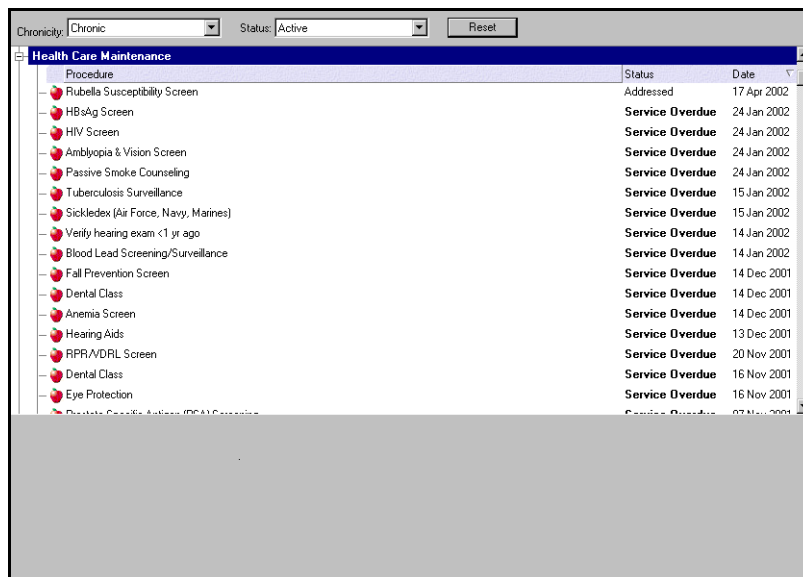
3. Click **Save**.

Note: Active problems added to the patient's problem list auto-age to **Acute-Inactive** after 180 days.

30.7 Accessing Healthcare Maintenance

Health Care Maintenance items are the same wellness reminders found in the Wellness module, and the Reminders tab of the A/P module. Any expired medications for the patient also display as Healthcare Maintenance items.

Healthcare Maintenance items can be viewed by clicking the plus sign next Healthcare Maintenance. The list of wellness reminders displays.



Procedure	Status	Date
Rubella Susceptibility Screen	Addressed	17 Apr 2002
HBsAg Screen	Service Overdue	24 Jan 2002
HIV Screen	Service Overdue	24 Jan 2002
Amblyopia & Vision Screen	Service Overdue	24 Jan 2002
Passive Smoke Counseling	Service Overdue	24 Jan 2002
Tuberculosis Surveillance	Service Overdue	15 Jan 2002
Sickledex (Air Force, Navy, Marines)	Service Overdue	15 Jan 2002
Verity hearing exam <1 yr ago	Service Overdue	14 Jan 2002
Blood Lead Screening/Surveillance	Service Overdue	14 Jan 2002
Fall Prevention Screen	Service Overdue	14 Dec 2001
Dental Class	Service Overdue	14 Dec 2001
Anemia Screen	Service Overdue	14 Dec 2001
Hearing Aids	Service Overdue	13 Dec 2001
RPR/VDRL Screen	Service Overdue	20 Nov 2001
Dental Class	Service Overdue	16 Nov 2001
Eye Protection	Service Overdue	16 Nov 2001
Respiratory Specific Antigen (RSA) Screening	Service Overdue	07 Nov 2001

Figure 30–9: Healthcare Maintenance

Note: Select a maintenance item and click **Guidelines** on the Action bar to view a description of the item.

Tip:
 Select a Healthcare Maintenance Item and press **F1** to view the clinical guidelines associated with the item.

31.0 QUESTIONNAIRE SETUP

31.1 Questionnaire Setup Overview

The Questionnaire Setup module allows you to create and modify questionnaires. Once created, you can modify, copy, delete, and mark obsolete these questionnaires. An open encounter is not required for questionnaires to be created or modified. The Questionnaire Setup module can be accessed from the Folder List by expanding **Tools**.

Figure 31-1: Questionnaire Setup Module

31.1.1 In More Depth

The Status section of each questionnaire denotes the level of development or use of a questionnaire. A new questionnaire always starts out as In Development.

- Mark as Ready means the questionnaire is ready for use. A questionnaire must be marked Ready for Use before it can be used in the Patient Questionnaires module. Once marked, the status changes from In Development to Ready for Use.
- Mark as Obsolete means a questionnaire has been removed from circulation. A questionnaire that is marked obsolete can be made active again by selecting Ready For Use. New Version means a questionnaire can be modified and saved as different version of a specific questionnaire.

A questionnaire can be copied and saved as another questionnaire so that questions can be reused.

31.1.2 Creating a New Questionnaire

Follow the steps below to create a new questionnaire:

1. Click **New** on the Action bar. The New Questionnaire pane opens.

Figure 31-2: Questionnaire Setup — New Questionnaire

2. In the **Name** field, enter the name for the new questionnaire.
3. Select **Questionnaire** or **Test** from the Type drop-down list.

Note: The Status is *In Development* until you save the questionnaire.

4. Select the Level from the drop-down list.
5. Select the Owner from the drop-down list.
6. In the **Instructions to Display** field, enter any instructions related to the questionnaire for the patient.
7. Click **Add** to create a new question.

Note: The **Question No.** field is pre-populated in numerical order.

8. In the **Question Text** field, enter the question.
9. Select an answer type from the drop-down list. The **Answer Type** field allows different answer format styles to be assigned to the question.

- **Date:** This field is used for questions requiring a specified date to be entered as the answer.
- **Multiple Choice:** This field is used for questions where a single choice is available for selection.
- **Multi-Select:** This is used for questions where more than one answer can be selected.
- **Number:** This is used for questions requiring a number to be entered. A minimum or maximum amount can be specified.
- **Yes/No:** This is used for questions requiring a yes or no response.

The screenshot shows the 'Questionnaire/Test Setup' window. On the left is a tree view with categories: Questionnaires and Tests, Enterprise, MTF, Clinic, Questionnaires (containing GOLD MTF, Eds Latest Questionnaire Version 1, and Eds new questionnaire (Version 2)), Tests, Personal, and Unassigned. The main area is titled 'Eds Latest Questionnaire' and contains the following fields and options:

- Name: Eds Latest Questionnaire
- Type: Questionnaire
- Version: 2
- Status: In Development
- Level: Clinic
- Owner: GOLD MTF
- ☒ Associate this questionnaire with the patient record?
- ☐ Require a Provider for this questionnaire?
- Instructions to Display: Answer each question as honestly as possible
- Question Preview:

Eds Latest Questionnaire
Answer each question as honestly as possible

 - When was you last cholestereol check?
Answer:
 - How much do you think you eat
☐ Too much ☐ Too little ☐ Not enough ☐ The right amount
 - When do you eat foods that are high in fat?
☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacks
- Question No.: (Buttons: Import, Add, AutoOne)
- Question Text:
- Answer Type: Date

Figure 31–3: Questionnaire Answer Format Styles

- When you have finished adding questions, click **Save** on the Action bar to save the questionnaire as completed.
- Click **Mark as Ready** on the Action bar.

Note: The status changes from **In Development** to **Ready for Use**. The questionnaire must be marked **Ready for Use** before it can be used in the Patient Questionnaires module.

31.2 Copying a Questionnaire

A questionnaire can be copied and saved as another questionnaire so that questions can be reused.

Follow the steps below to copy a questionnaire:

- Select the questionnaire you want to copy from the **Questionnaire** list.
- Click **Copy** on the Action bar. The Copied Questionnaire displays.

3. In the **Name** field, enter the name of the questionnaire.
4. Select the question you want to modify, if necessary.
 - Make the modification.
5. Click **Save** on the Action bar.
6. Click **Mark as Ready** to mark the test as ready for use.

31.3 Deleting a Questionnaire

Only questionnaires that have never been used can be deleted. If a questionnaire is not used, it can be deleted so it does not appear in the Questionnaire list available in either the Questionnaire Setup or Patient Questionnaire Setup.

Follow the steps below to delete a questionnaire:

1. Select the questionnaire you want to delete from the Questionnaire list.
2. Click **Delete** on the Action bar.
3. Click **Yes** at the delete confirmation prompt.

31.4 Importing a Questionnaire or Question into a Questionnaire

Entire questionnaires or selected questions can be imported into questionnaires.

Follow the steps below to import a questionnaire or question into a questionnaire:

1. Select the questionnaire into which you want to import.
2. Click **Import**.
3. Click **OK** at the import questionnaire prompt.

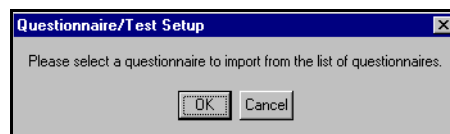


Figure 31–4: Import Questionnaire Prompt

4. Select the questionnaire you want to import from the Questionnaire list. The Import Questionnaire window opens.

Figure 31–5: Import Question Window

5. Click the question(s) you want to import.
6. Click **Import**. The questions are imported after the last question in the questionnaire.
7. Click **Save**.

31.5 Maintaining Questionnaires

The Status section of each questionnaire denotes the level of development or use of a questionnaire. A new questionnaire always starts out as In Development.

- **Mark as Ready:** This marks the questionnaire as ready for use.
- **Mark as Obsolete:** This allows a questionnaire to be removed from circulation.
- **New Version:** This allows a questionnaire to be modified into another version of a specific questionnaire.

Follow the steps below to mark a questionnaire as ready:

1. From the Questionnaires listed in the side bar, select the questionnaire to be marked as Ready for Use.
2. From the Questionnaire Set Up module, click the **Actions** pull-down menu and select **Mark as Ready**. Once marked ready, the questionnaire is available for use. The Status bar reflects the questionnaire as Ready for Use.

Follow the steps below to mark a questionnaire as obsolete:

1. From the questionnaires listed in the side bar, select the questionnaire to be marked obsolete.

2. From the Questionnaire Set Up module, click the Actions pull-down menu and select **Mark Obsolete**. Once marked Obsolete, the questionnaire is not available for use. The Status bar reflects the questionnaire as Obsolete.

Note: A questionnaire that is marked obsolete can be made active again by selecting **Ready For Use**.

Follow the steps below to mark a questionnaire as a new version:

1. From the Questionnaires listed in the side bar, select the questionnaire to be marked New Version.
2. From the Questionnaire Set Up module, click the Actions pull-down menu and select **New Version**. Once marked New Version, the questionnaire is available for use. The Status bar reflects the questionnaire as New Version.

Follow the steps below to delete a questionnaire:

Only questionnaires that have never been used can be deleted. If a questionnaire is not used, it can be deleted so it does not appear in the Questionnaire list available in either the Questionnaire Setup or Patient Questionnaire Setup. A questionnaire cannot be deleted if it has been used.

32.0 RADIOLOGY

32.1 Radiology Overview

The Radiology (Rad) module enables you to view radiology test result data for desired patients. Results are viewed, not ordered from this module. Radiology results are pulled from CHCS. An alert is triggered when new results are received. Use the A/P module to order radiology tests.

Refresh Close

20/202-45-5743 47yo F Col DOB:07 Jul 1957

Search Criteria: Filter... Summary View Time... Last 20 Display Criteria: Select All Results

Date	Procedure	Ordering Provider	MTF	Status	Result Code
27-Sep-2004 1123	Pelvis AP (Erect) Series Report PELVIS,ERECT AP	FRECHETTE, GEORGE	4th Medical Group	Complete	ABNORMALITY, ATTN. NEEDED
27-Sep-2004 1123	Right Ankle Series Report ANKLE,RT	FRECHETTE, GEORGE	4th Medical Group	Complete	NORMAL
27-Sep-2004 1123	L-Spine (2 Views) Series Report L-SPINE (2)	FRECHETTE, GEORGE	4th Medical Group	Complete	MINOR ABNORMALITY

ALEXANDER, VIOLET 20/202-45-5743 47yo 07 Jul 1957 F
***** PELVIS,ERECT AP *****
POC Enc: #E108675 POC Fac: 4th Medical Group
Status: Complete

Procedure: PELVIS,ERECT AP
Event Date: 27-Sep-2004 10:34:00
Order Comment: NO BRIEF COMMENT
Reason for Order: suspect fibroids
Exam #: 04002147
Exam Date/Time: 27-Sep-2004 11:23:00
Transcription Date/Time: 27-Sep-2004 11:24:00
Provider: FRECHETTE, GEORGE
Requesting Location: BLUE MTF SEYMOUR JOHNSON AFB, NC
Status: COMPLETE
Result Code: ABNORMALITY, ATTN. NEEDED
Interpreted By: FRECHETTE, GEORGE

05 Oct 2004 1207

Figure 32–1: Military Clinical Desktop—Radiology Module

32.2 Creating a Filter in the Radiology Module

The Filter tab on the Properties window enables you to view radiology results by selecting a previously saved filter from the drop-down list or creating a new filter.

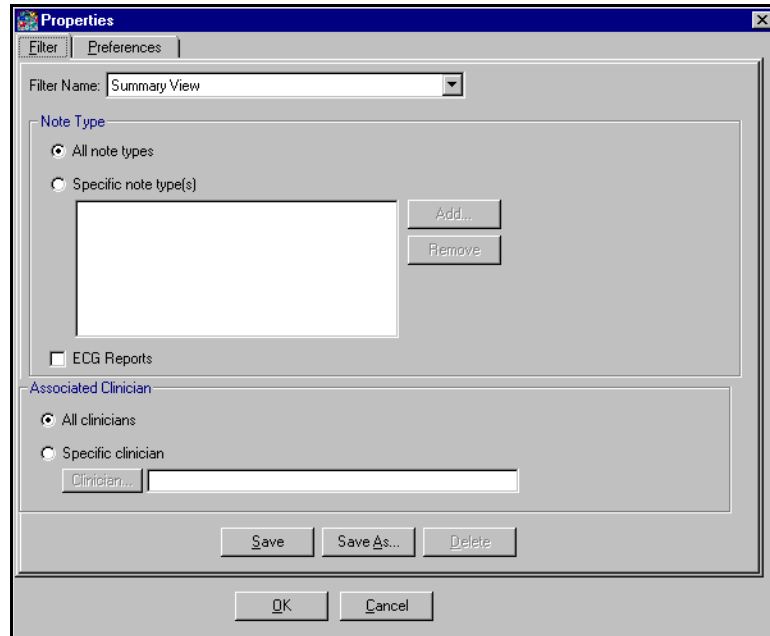


Figure 32-2: Radiology Properties Window—Filter Tab

Follow the steps below to create a new filter:

1. Click **Filter** on the Rad module. The Properties window opens.
2. Click the applicable radio button in the Note Type area.
 - **All Note Types:** If All Note Types is selected, all of the listed note types are displayed.
 - **Specific Note Type(s):** If Specific Note Type(s) is selected, click Add to open the Healthcare Data Dictionary Search window to search for and add specific clinical notes.
3. Click the applicable radio button in the Associated Clinician area.
 - **All Clinicians:** If All Clinicians is selected, all of the listed clinicians are displayed.
 - **Specific Clinician:** If Specific Clinician is selected, click **Clinician** to search for and select the specific clinician(s).
4. Click **Save As**. The Save As window opens.

Tip:

To delete a filter, select the filter from the drop-down list and click **Delete**. At the confirm deletion prompt, click **Yes**.

Note: If this is a change to a pre-existing filter, click **Save**.

5. Enter the name for the filter.
6. Click **Save**.

Note: To delete a filter, select the filter from the Filter Name drop-down list and click **Delete**. At the confirm deletion prompt, click **Yes**.

7. Click **OK**.

32.3 Setting Time Preferences in the Radiology Module

The Preferences tab on the Properties window allows you to customize the default times within the Radiology module.

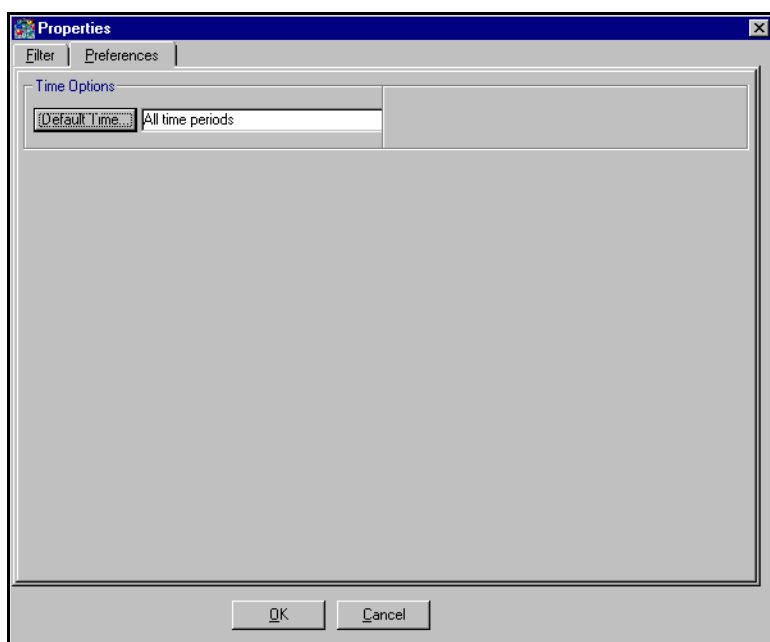


Figure 32-3: Radiology Properties Window—Preferences Tab

Follow the steps below to set time preferences:

1. Click **Options** on the upper, right corner of the workspace. The Properties window opens.
2. Click the Preferences tab.
3. Click **Default Time**. The Time Search window opens.

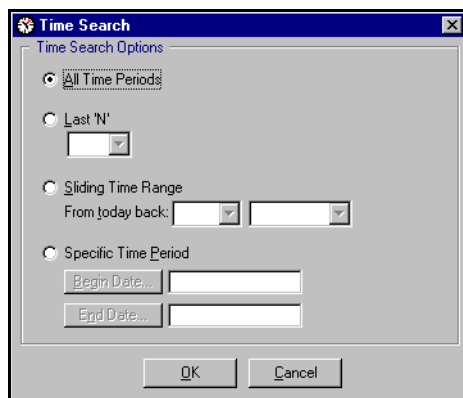


Figure 32-4: Time Search Window

4. Click the radio button for the applicable Time Search Option and click **OK**.
5. Click **OK**.

32.4 Viewing Radiology Results

Once the search criteria have been defined, the radiology results are displayed in the workspace.

Select the desired test data to be viewed by selecting the test name (i.e., mammogram). The data is displayed in the bottom of the Radiology Results workspace.

Note: When mammogram results are ready, a letter is sent to the patient notifying her that her results are ready. A copy of this letter can be found in the Clinical Notes module.

32.5 Printing Radiology Results

Follow the steps below to print the radiology results:

1. Select the test(s) you want to print.
2. On the **File** menu, scroll over Print and click **Rad Results**.

32.6 Copying Radiology Results to a Note

Once the radiology result is displayed, the result can be copied for use in other modules or can be copied directly into the Note area of the patient encounter.

Follow the steps below to copy radiology results to a note:

1. Select the desired result so the details display in the bottom of the Radiology module.

Date	Procedure	Ordering Provider	MTF	Status	Result Code
02 Jul 2001 1356	CT HEAD SCREEN WITHOUT CONTRAST MATERIAL CT Head Without Contrast Report	PROVIDER, DYLAN	NMC Portsmouth	Complete	NORMAL
02 Jul 2001 1342	ANKLE, TRAUMA RT Right Ankle Series Report	PROVIDER, DYLAN	NMC Portsmouth	Complete	ABNORMALITY, ATTN. NEEDED
02 Jul 2001 1342	ANKLE, TRAUMA RT Right Ankle (Trauma) Series Report	PROVIDER, DYLAN	NMC Portsmouth	Complete	ABNORMALITY, ATTN. NEEDED

PRACTICE, RICHARD 20/802-62-0416 40yo 16 Apr 1962 M

***** CT Head Without Contrast Report *****

Date: 02/Jul/2001
 POC Enc: #E5990663 POC Fac: NMC Portsmouth
 Status: Complete

Procedure: CT, HEAD SCREEN WITHOUT CONTRAST MATERIAL

Order Date/Time: 02 Jul 2001 1355

Order Comment: NO BRIEF COMMENT

Reason for Order: Research cause for Migrains

Exam #: 01000583

Transcription Date/Time: 02 Jul 2001 1356

Provider: PROVIDER, DYLAN

Requesting Location: DERMATOLOGY NMCP NAVAL MEDICAL CENTER, PORTSMOUTH

Status: COMPLETE

Result Code: NORMAL

Interpreted By: 41066 FRECHETTE, GEORGE

Approved By: 41066 FRECHETTE, GEORGE

Approved Date/Time: 02 Jul 2001 1356

Report Text: No abnormalities

06 May 2002 1131

Figure 32-5: Radiology Results Module (Copy Radiology Results)

2. Select the portion of the result to be copied by left-clicking and dragging with your mouse.
3. Perform a right-click on your mouse, then select either:
 - **Copy:** Copies the selection on the clipboard so it can be used in another location.
 - **Copy to Note:** Copies the details directly into the S/O area of the current encounter.

Note: An encounter must be open to utilize the **Copy to Note** function. The result is pasted directly into the patient encounter. Once copied, the result cannot be deleted from the note, so ensure that you only select the **Copy to Note** option once, to avoid duplicate entries in the note.

33.0 READINESS

33.1 Readiness Overview

The Readiness module displays information to determine whether the patient is ready for deployment. Most of the data displayed on the Readiness module is received from other sources. Data edited in the Readiness module does not update data in its original source.

The screenshot shows a software window titled "Military Clinical Desktop—Readiness Module". At the top, it displays patient information: "202-45-5743 47yo F Col DOB:07 Jul 1957" and a small "NKA Options" button. The main area is divided into four sections: "Lab Tests", "Screening Exams", "Profiles", and "Vision Readiness".

- Lab Tests:** Includes fields for HIV Done, G6PD, Sickle Cell, Blood Type, and DNA on File, each with a Date dropdown and a Result dropdown.
- Screening Exams:** Includes fields for Hearing Exam, Last Dental Exam, Medical Assessment (PE), Hearing Aid Required, Dental Readiness Classification, and Date Issued, each with a Date dropdown.
- Profiles:** Includes fields for Temporary Profile, Start Date, End Date, Diagnosis, and Limitation, each with a dropdown or text field.
- Vision Readiness:** Includes fields for Last Visual Acuity, Protective Insert, Required, Issued, and Date Issued, each with a dropdown or text field.

Figure 33–1: Military Clinical Desktop—Readiness Module

33.2 Modifying Readiness Information

Most of the data displayed in the Readiness module are downloaded from other sources. Editing data in the Readiness module does not update the data in its original source.

Follow the steps below to modify readiness information:

1. Click **Edit** on the Action bar.
2. Complete the following areas, as necessary:
 - Lab Tests
 - Screening Exams
 - Profiles
 - Vision Readiness

Tip:
The fields in the module are not active until you click **Edit**.

3. Click **Save**.

Note: If the Readiness information was modified, you must click **Save** before closing the module; otherwise, the changes will be lost.

34.0 REMINDER MAPPING

34.1 Reminder Mapping Overview

The Reminder Mapping module enables authorized users to set and modify default orders and other actions for Wellness Reminders. The default actions occur when the individual reminder is addressed. Users who do not have the appropriate roles assigned to them are able to view the Wellness Reminders and associated defaults, but cannot perform any other actions.

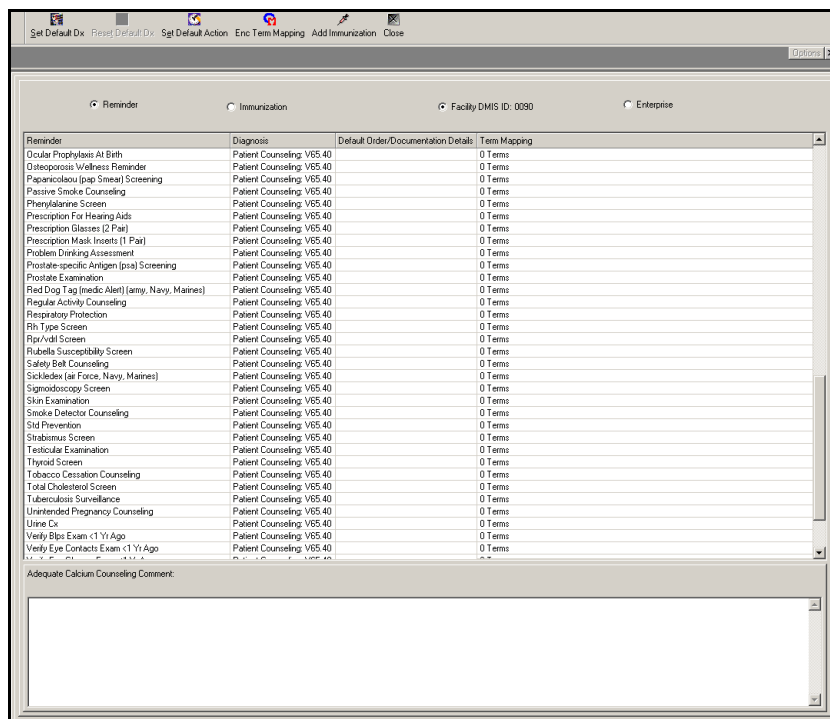


Figure 34–1: Military Clinical Desktop—Reminder Mapping Module

34.1.1 In More Depth

Upon opening the Reminder Mapping module, a list of all Wellness Reminders is displayed, along with default diagnoses, orders, and documentation details. Each of these defaults can be changed by Clinical Team Members with the appropriate privileges.

The default actions set up in the Reminder Mapping module allow for a more streamlined documentation of the Wellness reminders. Wellness Reminders can be met with the documentation of vital signs, the ordering of a lab or radiology procedure, the documentation of a MEDCIN term, or the documentation that counseling was completed.

The default actions set within the Reminder Mapping module are seen within the A/P module. The Reminders tab contains the active wellness reminders for a given patient as well as the default settings for each reminder. The A/P module is where a clinical

team member documents completed reminders; the Reminder Mapping module sets up the default actions that are completed when a reminder is addressed in the A/P module.

Note: A list of active Wellness reminders for the selected patient is displayed in the Reminders Mapping window (bottom left of the desktop) and in the A/P module on the Reminders tab.

34.1.2 Setting a Default Diagnosis

When a reminder is addressed for an individual patient, through the A/P module, the associated default diagnosis is added to the encounter automatically. The default diagnosis for Wellness Reminders is Patient Counseling V65.40, but this can be changed.

Follow the steps below to change the default diagnosis for a Reminder:

1. Select the Reminder and click **Set Default Dx** on the Action bar. The Default Diagnosis Search window opens.
2. Enter a search string in the Search field and click **Search**. The search results display.

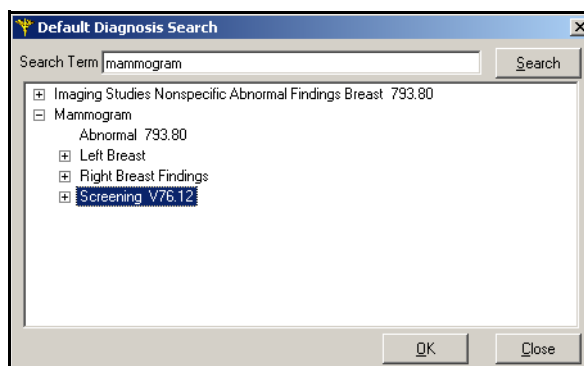


Figure 34-2: Default Diagnosis Search Window—Search Results

3. Select a Diagnosis and click **OK**. The selected diagnosis replaces the default diagnosis.

<input checked="" type="radio"/> Reminder <input type="radio"/> Immunization <input checked="" type="radio"/> Facility DMIS ID: 0090 <input type="radio"/> Enterprise			
Reminder	Diagnosis	Default Order/Documentation Details	Term Mapping
Hemoglobinopathy Screen	Patient Counseling: V65.40		0 Terms
Hiv Screen	Patient Counseling: V65.40		0 Terms
Hormonal Replacement Therapy Counseling	Patient Counseling: V65.40		0 Terms
Hot Water Counseling	Patient Counseling: V65.40		0 Terms
Mammogram Screening	Mammogram Screening V76.12 (MTF)		0 Terms
Maternal Serum Alpha-fetoprotein Counseling	Patient Counseling: V65.40		0 Terms
Multivitamin With Folate	Patient Counseling: V65.40		0 Terms

Figure 34-3: Default Diagnosis Changed

34.1.3 Resetting a Diagnosis to the Default Diagnosis

Select the Reminder with the diagnosis you want to reset and click **Reset Default Dx** on the Action bar to reset a diagnosis to the default diagnosis (Patient Counseling V65.40). The diagnosis is reset to the default diagnosis.

34.2 Setting a Default Action

Along with a default diagnosis, each reminder can have a default action. The action can be the placement of a lab, radiology or medication order, or the documentation of patient instructions, vital signs, or simply that the reminder was completed or ordered. When the reminder is addressed in the A/P module, the default action occurs automatically.

Follow the steps below to set a default action for a reminder:

1. Select the Wellness Reminder and click **Set Default Action** on the Action bar. The Set Facility Default Action pop-up menu opens.

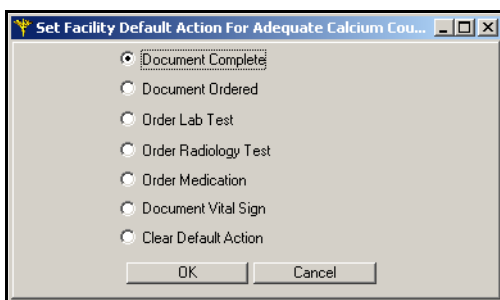


Figure 34–4: Set Facility Default Action Menu

You have multiple options from which to select.

34.2.1 Setting Document as the Default Action

If Document is the default action, CHCS II documents the reminder as complete or ordered in the comments section of the default diagnosis in the A/P module. For example, if the Nutrition Counseling reminder had a default diagnosis of Patient Counseling and a default action of Document Complete, the result in A/P would look like the figure below.

Priority	ICD	Diagnosis
1	V65.40	Patient Counseling:
	Comment	Nutrition Counseling Completed

Figure 34–5: Example of A/P Documentation

Follow the steps below to set the default action to Document (Completed, Ordered):

1. Click the appropriate radio button.
2. Click **OK**. Document (Complete, Ordered) is the default action for the reminder.

<input checked="" type="radio"/> Reminder	<input type="radio"/> Immunization	<input checked="" type="radio"/> Facility DMIS ID: 0090	<input type="radio"/> Enterprise
Reminder	Diagnosis	Default Order/Documentation Details	Term Mapping
Multivitamin With Folate	Patient Counseling: V65.40		0 Terms
Nutrition Counseling	Patient Counseling: V65.40	Document Nutrition Counseling Complete (MTF)	0 Terms
Ocular Prophylaxis At Birth	Patient Counseling: V65.40		0 Terms
Osteoporosis Wellness Reminder	Patient Counseling: V65.40		0 Terms

Figure 34–6: Reminder Set to Document Complete

34.2.2 Setting a Lab Order as the Default Action

Set the default action to automatically order a lab test when a reminder is addressed through the Reminders tab in the A/P module. In this case, the default diagnosis is documented and the default lab test is ordered and associated to the default diagnosis.

Follow the steps below to set the default action to Order a Lab Test:

1. Select the Wellness Reminder and click **Set Default Action** on the Action bar. The Set Facility Default pop-up menu opens.
2. Select Order Lab Test and click **OK**. The Lab order window displays.
3. Enter a search string in the Search field and click **Search**. The search results opens.

Figure 34–7: Order Lab Test Search Results

4. Select the lab order, fill in other fields as necessary, and click **OK**. The ordering of the lab test is the default action.

<input checked="" type="radio"/> Reminder			<input type="radio"/> Immunization	<input checked="" type="radio"/> Facility DMIS ID: 0124	<input type="radio"/> Enterprise
Reminder	Diagnosis	Default Order/Documentation Detail			
Adequate Calcium Counseling	Patient Counseling: V65.40				
Amblyopia & Vision Screen	Patient Counseling: V65.40	Document Amblyopia & Vision Screen			
Anemia Screen	Patient Counseling: V65.40	Order: Cholesterol (MTF)			
Anti-tobacco Counseling	Patient Counseling: V65.40	ORDER: (CHEST)			

Figure 34–8: Lab Order Default Added

Note: The lab test is not ordered until the provider addresses the Wellness Reminder in the A/P module during a patient encounter.

34.2.3 Setting a Radiology Order as the Default Action

Set the default action to automatically order a radiology test when a reminder is addressed through the Reminders tab in the A/P module. In this case, the default diagnosis is documented and the default radiology test is ordered and associated to the default diagnosis.

Follow the steps below to set the default action to Order a Radiology Test:

1. Select the Wellness Reminder, and click **Set Default Action** on the Action bar. The Set Facility Default pop-up menu opens.
2. Select Order Radiology Test and click **OK**. The Order Rad window opens.
3. Enter a search string in the Search field and click **Search**. The search results display.

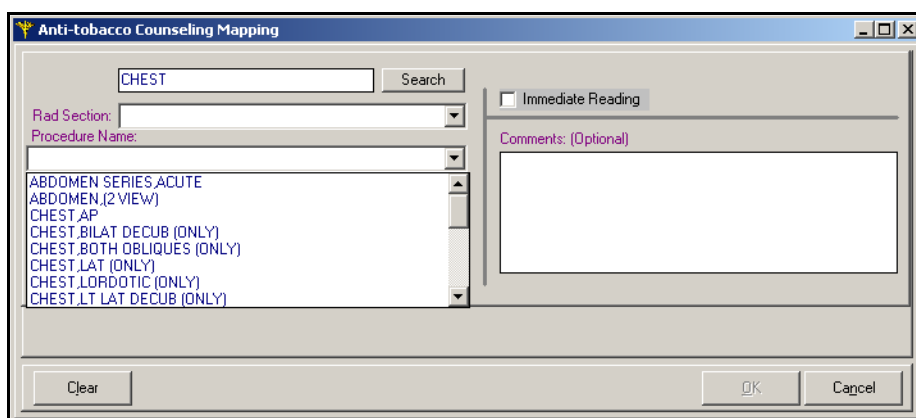


Figure 34-9: Rad Order Window—Search Results

4. Select the radiology test, fill in other fields as necessary, and click **OK**. The ordering of the radiology test is the default action.

Note: The radiology test is not ordered until the provider addresses the Wellness Reminder in the A/P module during a patient encounter.

34.2.4 Setting a Medication Order as the Default Action

Set the default action to automatically order a medication when a reminder is addressed through the Reminders tab in the A/P module. In this case, the default diagnosis is documented and the default medication is ordered and associated to the default diagnosis.

Follow the steps below to set the default action to Order a Medication:

1. Select the Wellness Reminder and click **Set Default Action** on the Action bar. The Set Facility Default pop-up menu opens.
2. Select Order Medication and click **OK**. The Order Medication window opens.

- Enter a search string in the Search field and click **Search**. The search results display.

Figure 34-10: Order Med Window – Search Results

- Select the medication, fill in other fields as necessary, and click **OK**. Ordering medication is the default action.

Reminder	Diagnosis	Default Order/Documentation Detail
Adequate Calcium Counseling	Patient Counseling: V65.40	
Amblyopia & Vision Screen	Patient Counseling: V65.40	Document Amblyopia & Vision Scree
Anemia Screen	Patient Counseling: V65.40	Order: Cholesterol (MTF)
Anti-tobacco Counseling	Patient Counseling: V65.40	ORDER: ALPRAZOLAM (XANAX)-
Baby Bottle Caries Counseling	Patient Counseling: V65.40	Document Baby Bottle Caries Coun-
Bulimic-Less Protection Speeches (Bulimic-Less)	Patient Counseling: V65.40	Document Bulimic-Less Protection

Figure 34-11: Medication Order Default Added

Note: The medication order is not ordered until the provider addresses the Wellness Reminder in the A/P module during a patient encounter.

34.2.5 Clearing a Default Action

Follow the steps below to clear a default action for a Wellness Reminder:

- Select the Wellness Reminder and click **Set Default Action** on the Action bar. The Set Facility Default pop-up menu opens.
- Select Clear Default Action and click **OK**. The Clear Reminder Option message displays.

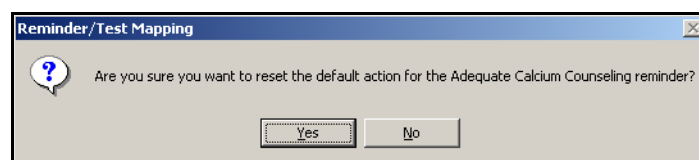


Figure 34-12: Clear Reminder Option Message

- Click **Yes**. The default action is cleared.

34.3 Mapping Encounter Terms

Follow the steps below to map encounter terms:

1. Click **Enc Term Mapping** on the Action bar. The Enc Term Search window opens.
2. Select the radio button next to the type of term to be mapped:
 - Other Therapies (patient instructions)
 - Procedure
 - Diagnosis
 - S/O Item
3. Enter a search string and click **Search**. The search results display.
4. Select a term and click **Add**. Your selection is added in the lower pane of the window.

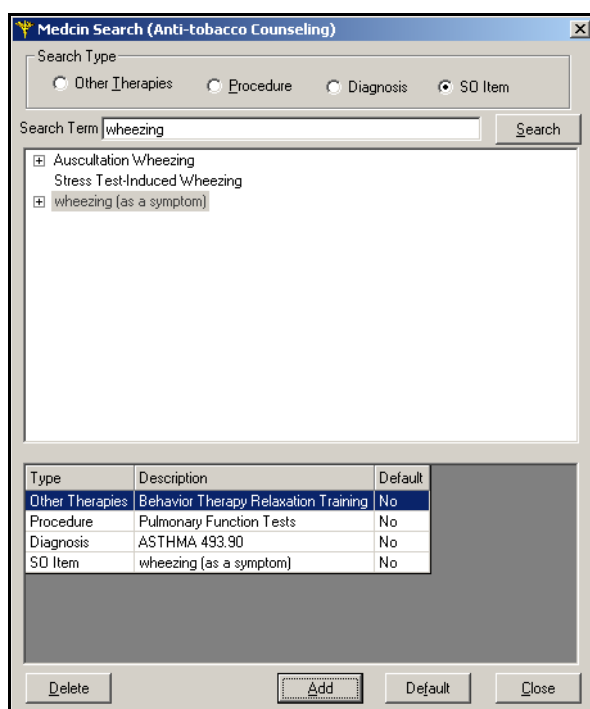


Figure 34-13: Selected Encounter Terms

34.3.1 Setting an Encounter Term as the Default

Follow the steps below to set one of the terms as the Default:

1. Select one of the terms.
2. Click **Default**. The terms Default column changes to Yes.

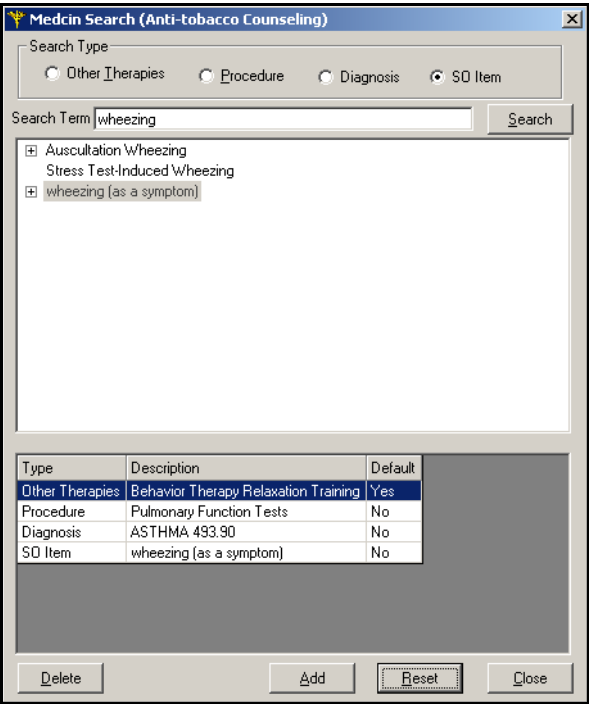


Figure 34–14: Term Item Set as Default

3. Click **Close**. Your Enc Terms selections have been added to the Reminder.

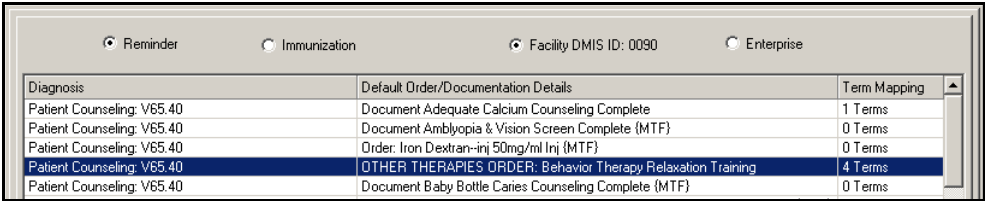


Figure 34–15: Defaults Set

Note: The default term is displayed and the Term Mapping column shows the total number of terms that you added (4).

34.4 Managing Immunization Reminders

34.4.1 Adding an Immunization

Immunizations must be added to the list before changing the default diagnosis or adding a default action.

Follow the steps below to locate and add an immunization to the list:

1. Click the **Immunization** radio button on the Reminder Mapping module. The Immunizations window opens.

Reminder	Diagnosis	Default Order/Documentation Details	Term Mapping
Anthrax	Patient Counseling: V65.40	Document Anthrax Complete (MTF)	0 Terms
Hep A Ped/adol, 2 Dose	Patient Counseling: V65.40		0 Terms
Mmr	Patient Counseling: V65.40	Document Mmr Ordered (MTF)	0 Terms
MmrV	Patient Counseling: V65.40	Document MmrV Ordered (MTF)	0 Terms
Varicella	Patient Counseling: V65.40	Document Varicella Complete (MTF)	0 Terms

Figure 34-16: Immunizations Window

- Click **Add Immunization** on the Action bar. The Immunization Search window opens.
- Enter a search string in the Search field and click **Search**. The search results display.

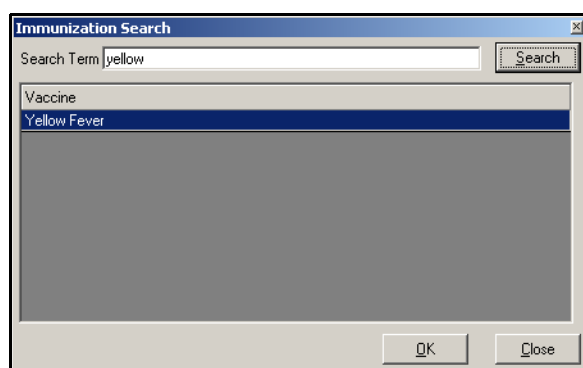


Figure 34-17: Immunizations Search Results

- Select the Immunization and click **OK**. The Immunization is added to the list.

Reminder	Diagnosis	Default Order/Documentation Details	Term Mapping
Anthrax	Patient Counseling: V65.40	Document Anthrax Complete (MTF)	0 Terms
Hep A Ped/adol, 2 Dose	Patient Counseling: V65.40		0 Terms
Mmr	Patient Counseling: V65.40	Document Mmr Ordered (MTF)	0 Terms
MmrV	Patient Counseling: V65.40	Document MmrV Ordered (MTF)	0 Terms
Varicella	Patient Counseling: V65.40	Document Varicella Complete (MTF)	0 Terms
Yellow Fever	Patient Counseling: V65.40		0 Terms

Figure 34-18: Immunization Added

34.4.2 Setting the Default Diagnosis for an Immunization

Follow the steps below to change the default diagnosis for a Reminder:

- Select the Reminder and click **Set Default Dx** on the Action bar. The Default Diagnosis Search window opens.
- Enter a search string in the Search field and click **Search**. The search results display.

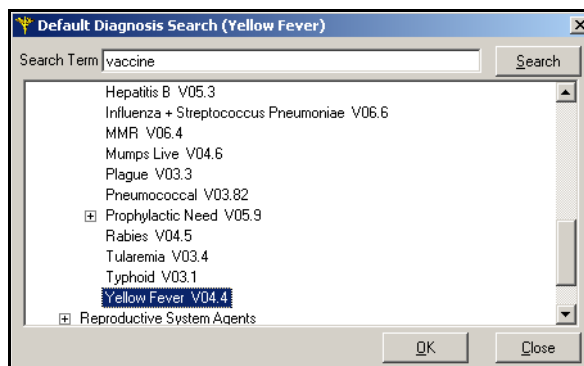


Figure 34-19: Default Diagnosis Search Window — Search Results — Immunization

3. Select a Diagnosis and click **OK**. The selected diagnosis replaces the default diagnosis.

<input type="radio"/> Reminder <input checked="" type="radio"/> Immunization <input type="radio"/> Facility DMIS ID: 0090			
Reminder	Diagnosis	Default Order/Documentation Details	Term Mapping
Anthrax	Patient Counseling: V65.40	Document Anthrax Complete (MTF)	0 Terms
Hep A Ped/adol, 2 Dose	Patient Counseling: V65.40		0 Terms
Mmr	Patient Counseling: V65.40	Document Mmr Ordered	0 Terms
MmrV	Patient Counseling: V65.40	Document MmrV Ordered	0 Terms
Varicella	Patient Counseling: V65.40	Document Varicella Ordered	0 Terms
Yellow Fever	Need For Vaccination Yellow Fever V04.4 (MTF)		0 Terms

Figure 34-20: Immunizations Window

34.4.3 Setting the Default Action for an Immunization

Follow the steps below to set the default action to Document (Completed, Ordered):

1. Select the immunization and click **Set Default Action** on the Action bar. The Set Immunizations Default Action window opens.

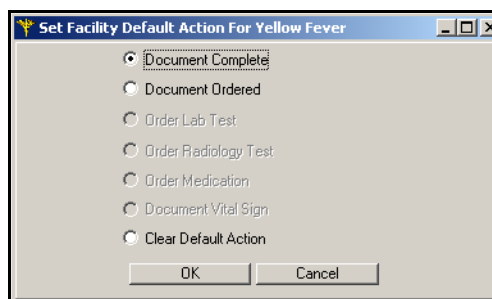


Figure 34-21: Set Immunizations Default Action Window

- Click the appropriate radio button.

Note: Only Document Complete or Document Ordered are available as default actions.

- Click **OK**. Document (Complete, Ordered) is the default action for the immunization.

<input type="radio"/> Reminder <input checked="" type="radio"/> Immunization Facility DMIS ID: 0090 <input type="radio"/> Enterprise			
Reminder	Diagnosis	Default Order/Documentation Details	Term Mapping
Anthrax	Patient Counseling: V65.40	Document Anthrax Complete {MTF}	0 Terms
Hep A Ped/adol, 2 Dose	Patient Counseling: V65.40		0 Terms
Mmr	Patient Counseling: V65.40	Document Mmr Ordered {MTF}	0 Terms
Mmriv	Patient Counseling: V65.40	Document Mmriv Ordered {MTF}	0 Terms
Varicella	Patient Counseling: V65.40	Document Varicella Complete {MTF}	0 Terms
Yellow Fever	Patient Counseling: V65.40	Document Yellow Fever Complete	0 Terms

Figure 34–22: Immunization Default Action Set

Note: The Immunization is not documented until the Reminder is addressed in the A/P module during a patient encounter. The documentation of an administered vaccine must be done in the Immunizations module.

35.0 REPORTS

35.1 Reports Overview

The Reports module consists of four different types of predefined reports used to collect statistical data to determine the needs of MTFs, Clinics, or Providers. In order to run Population Health Reports, special user privileges are required. If you do not have these privileges and wish to run these reports, please contact your system administrator. Depending on the selected report, the user can select a scope of MTF, Clinic/Lab, Provider, PCM, or Patient.

Appointment Description	Count
InProgress	7
Checked in on CHCS I	1
T-CON	1
Grand Total: 9	

Figure 35-1: Military Clinical Desktop—Reports Module

35.1.1 In More Depth

The Reports module consists of four different types of predefined reports—Customized, Preventive, Standard, and Population Health—used to collect statistical data.

Customized Reports enable the user to run different types of reports for a desired patient. Current pre-defined customized reports include:

- Allergy Verified (Audit)
- Appointments
- Consults
- Diagnoses
- Disposition

- E&M
- Lab Tests Ordered
- Medications Ordered
- Primary Diagnoses
- Procedures
- Radiology Tests

Figure 35-2: Customized Reports

There are 21 different Preventive Reports that can be run for a desired patient. Available reports include:

- 2 Year Olds, DTP/OPV/MMR Immunizations
- 2 Year Olds, Hepatitis B Immunizations
- 2 Year Olds, Varicella Immunization
- Cholesterol Screening Aggregate
- CPS Services Due
- CPS Summary
- Discontinued Services Risk
- High Cholesterol Follow-Up Counseling
- High Cholesterol Follow-Up Repeat
- High Cholesterol HDL/LDL Follow-Up
- Immunizations Active Duty Hepatitis A-1 Dose
- Immunizations Active Duty Hepatitis A-2 Dose
- Mammography, Have Not
- Mammography, Query for
- MMR #2, HBV #3, Varicella and TD Immunizations for 13 year old

Figure 35–3: Preventive Report

There are 13 different predefined Standard Reports that can be run. Available reports include:

- Alphabetic Patient List for Encounters
- Appointment by Status for Encounters
- Diagnoses
- Inpatient Workload
- Insurance Change
- Insurance Indicator
- Insurance Indicator Not Marked
- Outpatient Workload, for Clinic/Lab
- Patient Categories by Disposition
- Patient Categories by Provider
- Patient Encounter
- Procedures
- Readiness

Figure 35–4: Standard Report

There are different predefined Population Health reports that can be run. Population Health Reports include:

-

Figure 35–5: Population Health Report

35.2 Running Customized Reports

Customized Reports enable you to run different types of reports for a desired patient.

Current pre-defined customized reports include:

- Allergy Verified (Audit)
- Appointments
- Consults
- Diagnosis
- Disposition
- E&M
- Laboratory Tests
- Medication
- Primary Diagnosis
- Procedure
- Radiology Tests

Follow the steps below to run customized reports:

1. Select the report from the Report on drop-down list on the Customized tab.
2. Select a scope from the With Scope of drop-down list. Depending on the selection, a default MTF, clinic/lab, or provider displays.

Tip:

*If you select Clinic/ Lab or Provider from the drop-down list, click the **Lookup** icon to search for the desired clinic or provider.*

Note: Additional filters are available depending on the selected report. Use the drop-down lists to select the desired options.

3. Select a date range in the **From** and **To** fields.

Note: The date range defaults to the current date.

4. Click the checkbox if you want the report to display in a separate window.
5. Click the checkbox(es) if you want to group the results by clinic or provider.
6. Click **Run Report**. The customized report displays.

The screenshot shows a software window titled 'Customized' with tabs for 'Customized', 'Preventive', 'Standard', and 'Population Health'. The 'Customized' tab is active. It contains several input fields: 'Report on:' set to 'Disposition', 'With Scope of:' set to 'Clinic/Lab', and 'Further Narrowed by:' set to 'DERMATOLOGY NMCP'. Below these are 'From:' and 'To:' date pickers set to '10/1 /01' and '10/23/01' respectively. There is a checkbox for 'Display in separate window' and a 'Run Report' button. On the right, there are checkboxes for 'Group results by:' with options 'Clinic' and 'Provider'. Below the input fields is a toolbar with various icons and a status bar showing '1 of 1'. The main content area displays a report titled 'Disposition for Clinic/Lab' for 'Clinic/Lab: DERMATOLOGY NMCP (MEPRS: BAPA , DMIS: 0124)'. It shows a table of dispositions with counts for the period 'From: 01 Oct 2001' to 'To: 23 Oct 2001'. The table lists five categories: Admitted (1), Discharged to Home or Self-care (17), Left Against Medical Advice or Discontinued Care (6), Released without Limitations (307), and Returned to Duty (3). A 'Grand Total' of 334 is shown at the bottom right of the table.

Disposition	Count
Admitted	1
Discharged to Home or Self-care	17
Left Against Medical Advice or Discontinued Care	6
Released without Limitations	307
Returned to Duty	3
Grand Total	334

Figure 35–6: Customized Report

7. Click **Print Reports** to send the report to your local printer.

35.3 Running Preventive Reports

There are 22 different Preventive Reports that can be run for a desired patient.

Available reports include:

- 2 Year Olds, DTP/OPV/MMR Immunizations
- 2 Year Olds, Hepatitis B Immunizations
- 2 Year Olds, Varicella Immunization
- Cholesterol Screening Aggregate
- CPS Services Due
- CPS Summary
- Discontinued Services Risk
- High Cholesterol Follow-Up Counseling
- High Cholesterol Follow-Up Repeat

- High Cholesterol HDL/LDL Follow-Up
- Immunizations Active Duty Hepatitis A-1 Dose
- Immunizations Active Duty Hepatitis A-2 Dose
- Mammography, Have Not
- Mammography, Query for
- MMR #2, HBV #3, Varicella and TD Immunizations for 13 year old
- PAP Smear, Have Not
- Prevention Report Card
- Query for Potential Heavy Alcohol Use
- Safe Sex Counseling
- Tobacco Use Screening
- Tobacco, Advising Users to Quit

Tip:

*If you select **PCM**, the default PCM displays. If you select **Patient**, click the **Lookup** icon to search for the desired patient. You can also search for a different PCM.*

Follow the steps below to run preventive reports:

1. Select the report from the Report on drop-down list on the Preventive tab.
2. Select a scope from the With Scope of drop-down list.

Note: Additional filters are available depending on the selected report. Use the drop-down lists to select the desired options.

3. Select a date range in the **From** and **To** fields.

Note: The date range defaults to the current date.

4. Click the checkbox if you want the report to display in a separate window.
5. Click **Run Report**. The customized report displays.

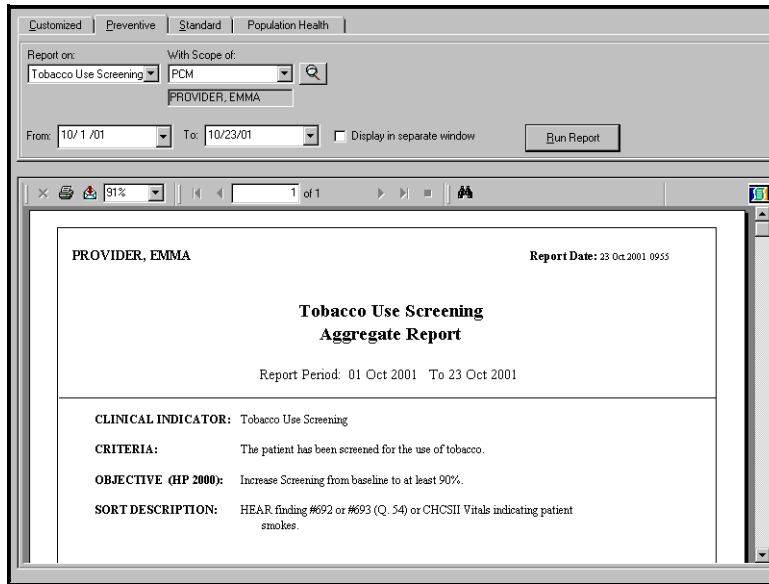


Figure 35–7: Preventive Report

6. Click **Print Reports** to send the report to your local printer.

35.4 Running Standard Reports

There are 13 different predefined Standard Reports that can be run.

Available reports include:

- Alphabetic Patient List for Encounters
- Appointment by Status for Encounters
- Diagnosis
- Inpatient Workload
- Insurance Change
- Insurance Indicator
- Insurance Indicator Not Marked
- Outpatient Workload
- Patient Categories by Disposition
- Patient Categories by Provider
- Patient Encounter
- Procedures
- Readiness

Follow the steps below to run standard reports:

1. Select the report from the Report on drop-down list on the Standard tab.

Tip:
Depending on the selected report, you can select a scope of MTF, Clinic/Lab, Provider, PCM, or Patient. Click the **Lookup** icon to search for the desired scope option. Additional scopes are available depending on the selected scopes.

2. Select a scope from the With Scope of drop-down list.
3. Select a date range in the **From** and **To** fields.

Note: The date range defaults to the current date.

4. Click the checkbox if you want the report to display in a separate window.
5. Click the checkbox(es) if you want to group the results by clinic or provider.
6. Click **Run Report**. The customized report displays.

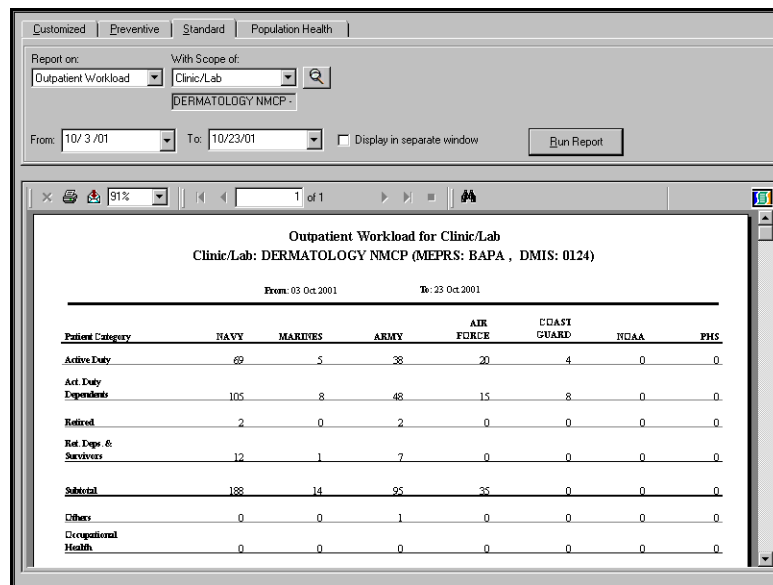


Figure 35-8: Standard Report

7. Click **Print** to send the report to your local printer.

35.5 Running Population Health Reports

There are different pre-defined Population Health reports that can be run.

Note: In order to run Population Health Reports, special user privileges are required. If you do not have these privileges and wish to run these reports, please contact your system administrator.

Follow the steps below to run a Population Health report:

1. Select the report from the Report on drop-down list on the Population Health tab.

2. Select a scope from the With Scope of drop-down list.

Note: Depending on the selected report, you can select a scope of MTF, Clinic/Lab, Provider, PCM, or Patient. Click the **Look up** icon to search for the desired scope option. Additional scopes are available depending on selected scopes.

3. Select a date range in the **From** and **To** fields.

Note: The date range defaults to the current date.

4. Click the checkbox if you want the report to display in a separate window.
5. Click **Run Report** to run the customized report.
6. Click **Print** to send the report to your local printer.

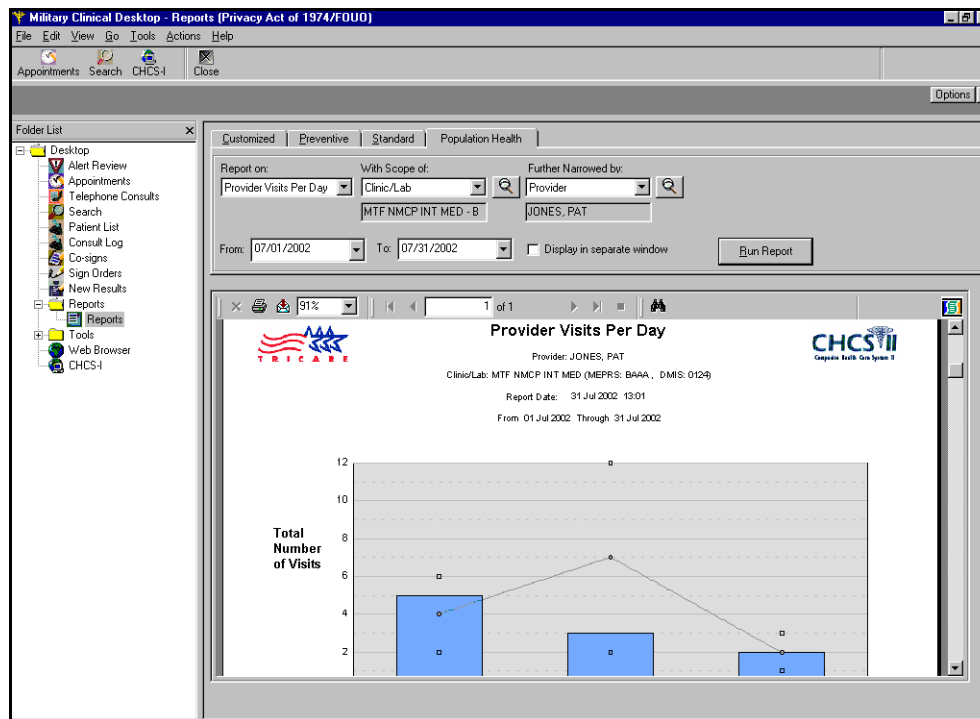



Figure 35-9: Population Health Tab

35.6 Exporting a Report

Follow the steps below to export a report:

1. Run the selected report.
2. Click the **Export Report**  icon. The Export window opens.
3. Select a **Format** from the drop-down list.
4. Select a **Destination** from the drop-down list.

5. Click **OK**.

36.0 Rx ALTERNATIVES

36.1 Drug (RX) Alternatives Overview

The RX Alternatives module allows you to track the cost of primary and alternative medications. When you add the cost associated with a medication in this module, the information is used in populating population health medication cost reporting data.

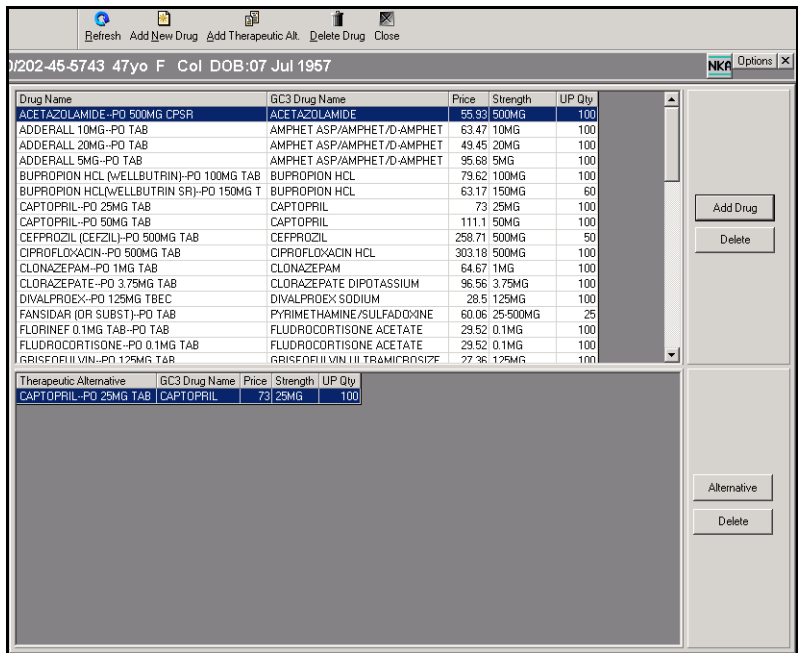


Figure 36-1: Military Clinical Desktop—RX Alternatives Module

36.2 Setting Drug Display Options

The Drug Display Options window lets you establish the type of data that displays when primary and alternative medications are added to the RX Alternatives module.

Follow the steps below to set the drug display options:

1. On the RX Alternatives module, click **Options** to open the Drug Display Options window.

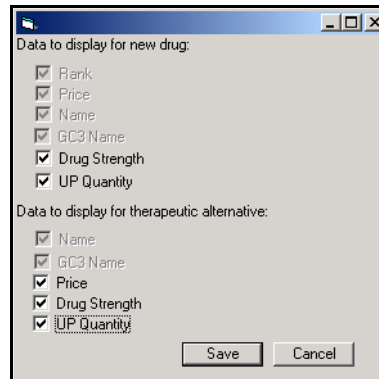


Figure 36–2: Drug Display Options Window

2. Select data options to display for the new drug:
 - Price
 - Name
 - Drug Strength
 - UP Quantity
3. Select data options to display for therapeutic alternative drugs:
 - Name
 - Price
 - Drug Strength
 - UP Quantity
4. Click **Save**.

36.3 Adding a New Drug

The Select Drugs window allows you to add new drug cost information to the RX Alternatives module. You can add drugs according to their name or description.

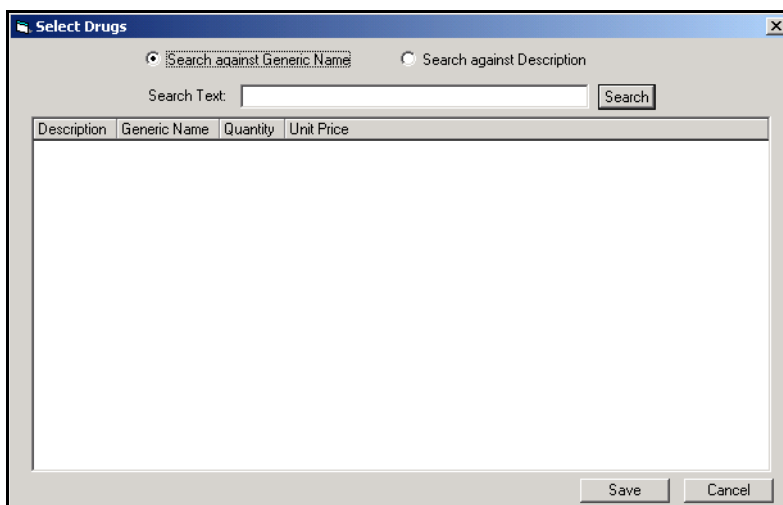


Figure 36-3: Select Drugs Window

Follow the steps below to add a new drug:

1. On the RX Alternatives module, click **Add New Drug** to open the Select Drugs window.
2. If you want to search for the drug by name, select **Search against Generic Name**.
3. If you want to search for the drug by description, select **Search against Description**.
4. In the **Search Text** field, enter the drug name or description.
5. Click **Search**.
6. Select the medication you want to add.

Note: Press the **Ctrl** key on the keyboard while you are selecting each medication to select more than one medication.

7. Click **Save**. You are returned to the RX Alternatives module.

Tip:

*If you do not see the added medication(s), on the RX Alternatives module, click **Refresh**.*

36.4 Adding Therapeutic Alternatives

The Select Therapeutic Alternative window allows you to add therapeutic alternative drug cost information to the RX Alternatives module for selected primary drugs. You can add therapeutic alternatives according to their name or description.

Note: You must have a primary drug selected before you can add a therapeutic alternative.

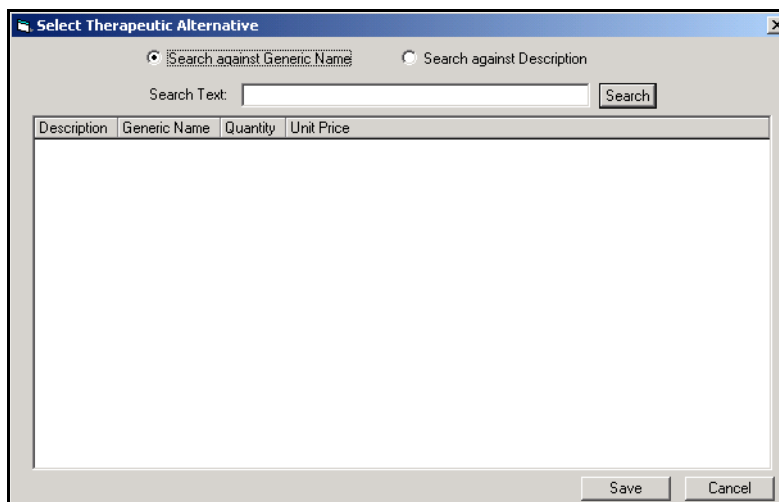


Figure 36-4: Select Therapeutic Alternative Window

Follow the steps below to add therapeutic alternatives:

1. On the RX Alternatives module, click **Add Therapeutic Alt** to open the Select Therapeutic Alternative window.
2. If you want to search for the drug by name, select **Search against Generic Name**.
3. If you want to search for the drug by description, select **Search against Description**.
4. In the Search Text field, enter the drug name or description.
5. Click **Search**.
6. Select the medication you want to add.
7. Click **Save**. You are returned to the RX Alternatives module.

Tip:

*If you do not see the added medication(s), on the RX Alternatives module, click **Refresh**.*

36.5 Deleting a Drug

Follow the steps below to delete a drug from the RX Alternatives module:

1. In the RX Alternatives module select the primary or alternative drug you want to delete.
2. On the action bar, click **Delete Drug**.
3. At the Delete Drug Ranking confirmation prompt, click **Yes**.

Tip:

*If you want to delete the therapeutic alternative but keep the primary drug, in the Therapeutic Alternative area, select the alternative and click **Delete**.*

37.0 SCREENING (REASON FOR VISIT)

37.1 Screening Overview

The Screening module allows for the documentation of the screening information; from the reason for visit, to injury and accident details, female specific information, and Wellness Reminders.

The Screening module is made up of two tabs:

- **Reason for Visit:** Allows you to document why the patient has an appointment and other screening information.
- **Due Reminders:** Displays due reminders from the Wellness module as health maintenance items for the patient.

0/202-45-5743 47yo F Col DOB:07 Jul 1957

Reason For Visit Due Reminders

Appointment Reason for Visit: Cough and fever

Select Reason(s) for Visit (Chief Complaint):

Patient Problem List: ESSENTIAL HYPERTENSION BENIGN
IRON DEFICIENCY ANEMIA
METRORRHAGIA

Clinic Favorites List: No Clinic Favorites

Search: Find Now

Add Remove

Selected Reason(s) for Visit:

Selected Reason(s) for Visit	New vs. Follow-Up	Comments
UPPER RESPIRATORY INFECTION	New	

Appointment Classification

☒ Outpatient ☐ Inpatient ☐ Observation

Encounter Context

☒ Related to Injury/Accident?

Female Only Data

☐ Pregnant ☒ Last Menstrual Period 9/30/2004

☐ Post Menopause ☐ Estimated DOB 10/4/2004

☐ Post Hysterectomy

G P A LC

Birth Control Method (optional)

☒ Birth Control Pill

☐ Abstinence

☐ Condom

☐ Diaphragm

☐ Foam

☐ Intramuscular Injection (e.g. Depoprovera)

If the patient is pregnant, the Last Menstrual Period and Estimated DOB are required to be entered before encounter is signed. All other fields are optional.

Comments Spec Wk Status OK Cancel

Figure 37-1: Military Clinical Desktop—Screening Module—Reason for Visit Tab

37.2 Adding an Additional Provider

An additional provider can be added to an encounter to receive credit for work performed on a patient.

Follow the steps below to add an additional provider:

1. On the Action bar, click **Add Providers**. The Provider and Roles window is displayed.

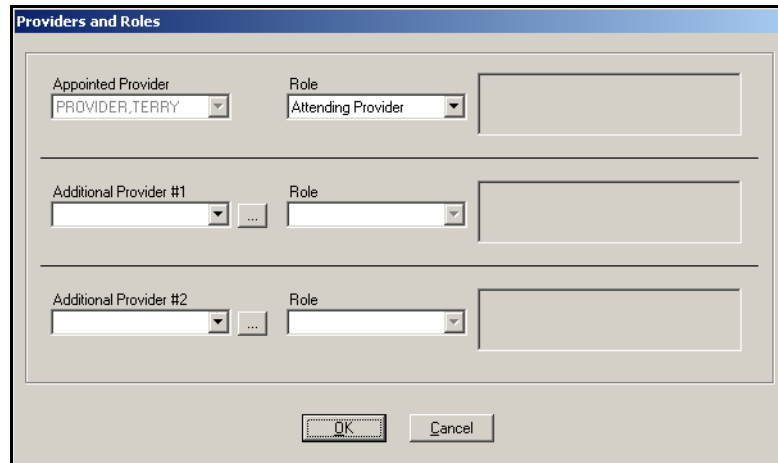
The 'Providers and Roles' window is a dialog box with a title bar. It contains three sections for adding providers. The first section has a dropdown for 'Appointed Provider' (showing 'PROVIDER, TERRY') and a dropdown for 'Role' (showing 'Attending Provider'). The second section has a dropdown for 'Additional Provider #1' and a button with three dots. The third section has a dropdown for 'Additional Provider #2' and a button with three dots. Each section has a large empty text box to the right. At the bottom are 'OK' and 'Cancel' buttons.

Figure 37-2: Providers and Roles Window

2. Select the type of clinician you want to add.
3. In the Additional Provider #1 area, click the **ellipsis** button to search for a provider. The Clinician Search window opens.

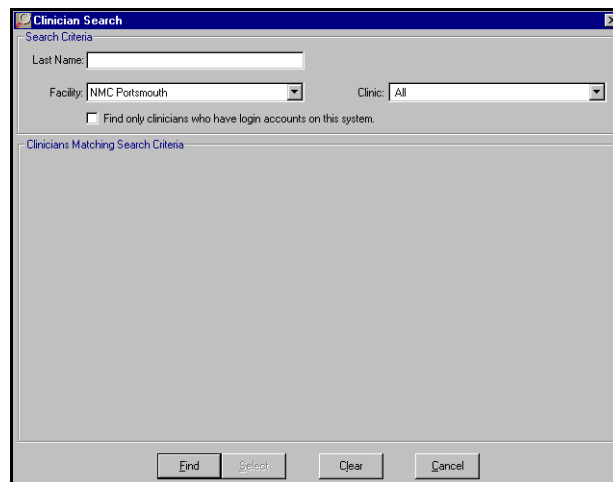
The 'Clinician Search' window has a title bar and a search criteria section. It includes a 'Last Name' text field, a 'Facility' dropdown (showing 'NMC Portsmouth'), and a 'Clinic' dropdown (showing 'All'). There is a checkbox labeled 'Find only clinicians who have login accounts on this system.' Below this is a large empty area labeled 'Clinicians Matching Search Criteria'. At the bottom are 'Find', 'Select', 'Clear', and 'Cancel' buttons.

Figure 37-3: Clinician Search Window

4. In the **Last Name** field, enter the last name of the desired clinician.
5. Select a facility from the drop-down list.
6. Select a clinic from the drop-down list.
7. Click the **Find only clinicians who have login accounts on this system** to view only providers associated with CHCS II.
8. Click **Find**. The results are displayed in the bottom half of the Clinician Search window.
9. Select the desired clinician.
10. Click **Select**. The name populates in the **Additional Provider** field on the Provider and Roles window.

11. Click the Role drop-down list to select the additional provider's role.

Note: Repeat steps 2-11 if you want to add a second additional clinician.

12. Click **OK**. The clinician(s) is(are) added to the appointment.

37.3 Documenting the Reason for Visit

Follow the steps below to document the reason for visit:

- On the Reason For Visit tab, select a reason for the visit from one of the following areas:
 - Patient Problem List:** Displays entire history of the patient's past problems.
 - Clinic Favorites List:** Displays a list of reasons specific to the clinic.
 - Search:** Allows you to select a reason not listed in the Patient Problem List or the Clinic Favorites List. Enter the desired reason (a minimum of two letters must be typed) in the search field and click **Find Now** to conduct a search. The search results appear in the third column.
- Click **Add**. The selected reason displays in the Selected Reason(s) for Visit area.

Figure 37–4: Reason for Visit Tab

Note: Reasons from the patient's problem list are marked as Follow-Up and reasons from the other lists are marked as New. Select the reason for visit and click in the **New vs. Follow-up** column to change the status. A drop-down list displays, allowing a new selection.

3. Click inside the Comments field next to the reason for visit to enter additional comments for the selected reason for visit.

Note: You can also add general comments at the bottom of the module.

4. Complete the following:
 - **Appointment Classification:** This is determined by CHCS and cannot be changed.
 - **Special Work Status:** Click **Spec Wrk Status** to view the Special Work Status window. Click the checkbox next to the applicable work status and click **Save**.
 - **Related to Injury/Accident?:** If the appointment is related to an injury or an accident, select this checkbox. The Date and Related Cause Code window appears.

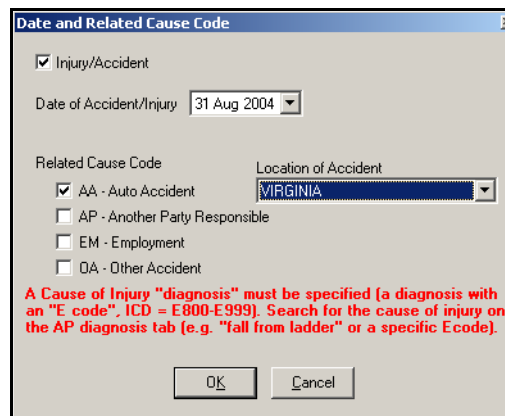


Figure 37-5: Date and Related Cause Code Window

- Complete all fields and click **OK**. Notice the checkbox indicating that the date and Related Cause Code have been entered.

Note: An encounter marked as related to an injury or accident is required to contain an E-code as one of the diagnoses. A notification appears when you attempt to close the A/P module or sign the encounter if the encounter is marked as related to an injury or accident and no E-code (diagnosis) was selected.

5. Click **OK**.

37.4 Adding Female Only Data

The fields associated with Female Only Data display for female patients 12 years of age or older.

Follow the steps below to add female only data:

1. In the Female Only Data area, select the checkboxes to all the fields that apply.

- **Pregnant**

Note: If the patient is pregnant, the Last Menstrual Period and the Estimated DOB are required fields.

- **Post Menopause**
- **Post Hysterectomy**
- **Last Menstrual Period:** Select this checkbox to activate the date drop-down field. Select the appropriate date.
- **Estimated DOB:** Select this checkbox to activate the date drop-down field. Select the appropriate date.

Note: On the electronic SF600, the estimated DOB is written as the EDC (Estimated Date of Confinement).

- **Birth Control Method:** Click the checkbox next to the appropriate birth control method.
- **G, P, A, LC:** Click the drop-down list and select the appropriate value.

37.5 Verifying Allergies

In every encounter, it is important to verify the patient's current allergies. The Screening module is the only module in the workflow where you can document patient allergies in the encounter note.

Follow the steps below to verify a patient's allergies during the screening process:

1. Click **Verify Allergy** on the Action bar. You are transferred to the Allergy module.
2. Verify the patient's allergies in the Allergy module and click the **Verified this Encounter** checkbox. This documents that the allergies have been verified on the Patient Encounter.
3. Close the Allergy module to return to the Screening module.

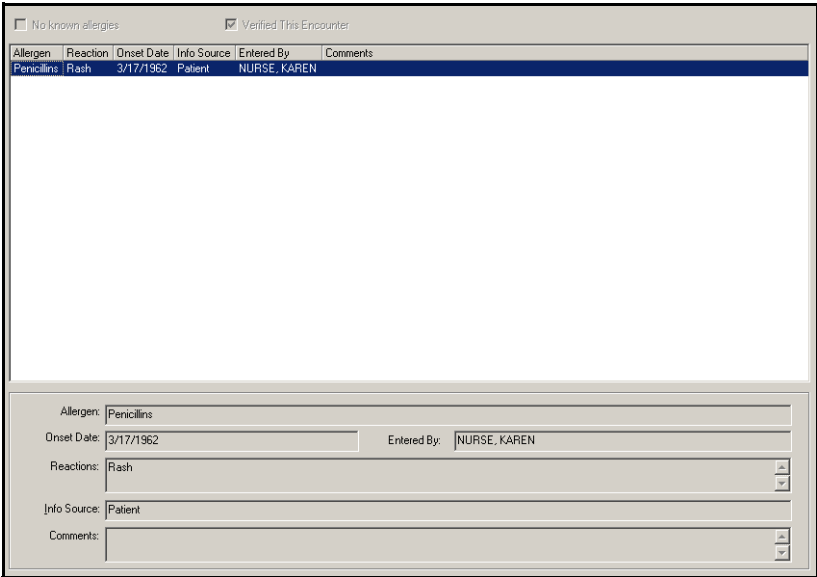


Figure 37–6: Verifying Allergies

37.6 Managing the Wellness Reminders

Wellness Reminders can be reviewed and addressed through the Screening module.

Follow the steps below to manage the wellness reminders:

- 1. Click the Due Reminders tab in the Screening module. A list of Healthcare Maintenance items display in the tab.

Tip:
These are the same reminders found under Healthcare Maintenance in the Reminders pan and below the Folder List on the Due Reminders tab in the Wellness module.

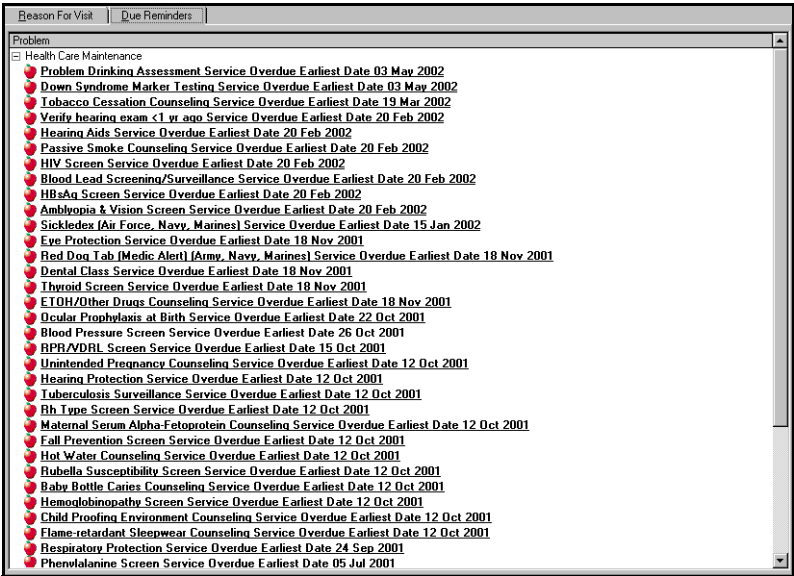


Figure 37–7: Due Reminders Tab (Screening Module)

- 2. Double-click a reminder. The Due Reminders tab in the Wellness module opens.

Due Reminders Documentation History Reminder History Wellness Schedule				
Time... All time periods				
Type	Status	Earliest Date	Recommended Date	Comment
Screening				
Amblyopia & Vision Screen	Service Overdue		20 Feb 2002	
Anemia Screen	Service Overdue		02 Jul 2001	
Blood Lead Screening/Surveillance	Service Overdue		20 Feb 2002	
Blood Pressure Screen	Service Overdue		26 Oct 2001	
Down Syndrome Marker Testing	Service Overdue		03 May 2002	
Fall Prevention Screen	Service Overdue		12 Oct 2001	
HBsAg Screen	Service Overdue		20 Feb 2002	
Hemoglobinopathy Screen	Service Overdue		12 Oct 2001	
HIV Screen	Service Overdue		20 Feb 2002	
Ocular Prophylaxis at Birth	Service Overdue		22 Oct 2001	
Phenylalanine Screen	Service Overdue		05 Jul 2001	
Problem Drinking Assessment	Service Overdue		03 May 2002	
Rh Type Screen	Service Overdue		12 Oct 2001	
RPR/VDRL Screen	Service Overdue		15 Oct 2001	
Rubella Susceptibility Screen	Service Overdue		12 Oct 2001	
Thyroid Screen	Service Overdue		18 Nov 2001	
Tuberculosis Surveillance	Service Overdue		12 Oct 2001	
Counseling				
Readiness				

Figure 37-8: Due Reminders Tab (Wellness Module)

- Document the selected due reminder.
- When you have completed documenting the due reminder in the Wellness module, close the Wellness module to return to the Due Reminders tab in the Screening module.

38.0 SCREENING NOTIFICATION

38.1 Screening Notification Overview

The Screening Notification module allows you to notify patients via e-mail or letter when a wellness reminder is scheduled. The Screening Notification module interfaces with the Wellness module in tracking wellness reminders.

The Screening Notification module allows you to search for patients by Defense Medical Information System ID (DMIS ID) or Primary Care Manager (PCM).

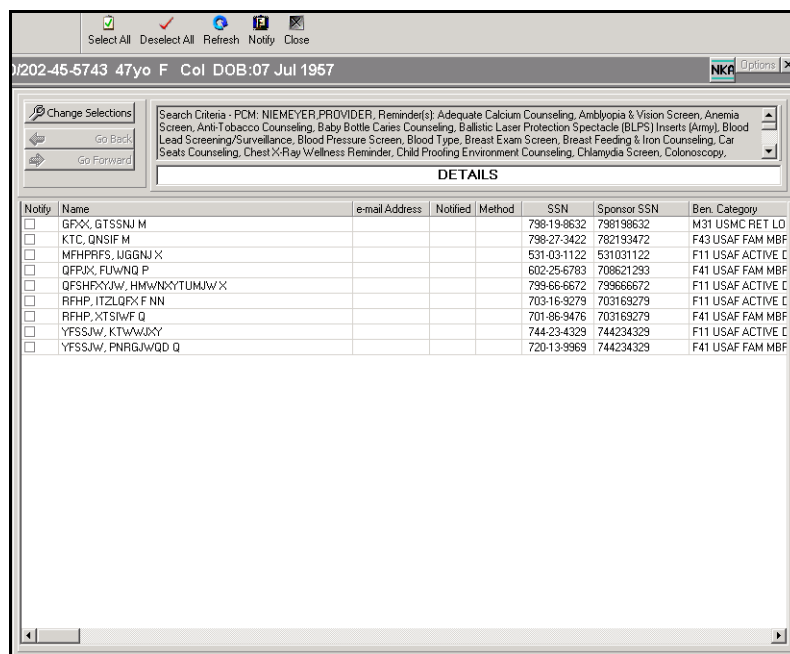


Figure 38-1: Military Clinical Desktop—Screening Notification Module

38.1.1 In More Depth

Patients listed in the Screening Notification module have a date in the corresponding wellness reminder column that determines when they need to be notified. The user can notify patients by e-mail or letter. The Properties dialog box is used to determine how the patient is notified. The properties selected become the user's default settings.

Screening service results depend on the selected wellness reminder and the number of patients scheduled to be notified for the reminder. Viewing results for an entire DMIS ID may produce extensive feedback and take an extended amount of time; therefore, it may be more beneficial to view results for a specific PCM.

38.2 Selecting Screening Notification Reminder Search Options

Screening service results depend on the selected wellness reminder and the number of patient(s) scheduled to be notified for the reminder. Viewing results for an entire DMIS ID may produce extensive feedback and take an extended amount of time; therefore, it may be more beneficial to view results for a specific PCM.

Follow the steps below to select Screening Notification reminder search options:

1. Click **Change Selections**, the Screening Notification Reminder Search Options window opens.

Screening Notification Reminder Search Options

Select reminder types for which you want to notify the patient if they are overdue or coming due.

Available Reminder(s)

- Adequate Calcium Counseling
- Amblyopia & Vision Screen
- Anemia Screen
- Anti-Tobacco Counseling
- Baby Bottle Caries Counseling

Selected Reminder(s)

Define Source

DMIS ID Search

PCM USER, TEST Search

☒ Narrow Result(s) By Due Date

7 /13/2004 8 /13/2004

☒ Include Patients Who Have Been Previously Notified

Method All

☐ Narrow Result(s) By Date Notified

7 /13/2004 8 /13/2004

OK Cancel

Figure 38–2: Screening Notification Reminder Search Options Window

2. In the **Available Reminder(s)** list, select the reminder(s).

3. Click the **Associate Down Arrow** button to move the reminder to the **Selected Reminder(s)** list.

Note: Select the available reminders while pressing the **Ctrl** key on your keyboard to select multiple reminders.

Note: Clicking the **Associate All Down Arrow** button moves all the Available Reminders to the Selected Reminders list.

Note: Selected reminders can be removed from the Selected Reminders list by selecting the reminders and clicking the **Unassociate Up Arrow** button.

4. Do one of the following:
 - If you want to search by DMIS ID, select the DMIS ID radio button and click **Search**.
 - If you want to search for patients associated with a primary care manager, select the **PCM** radio button and click **Search** to search for the provider.

Note: Performing a search for patients associated with a DMIS ID may take an extended period of time.

5. If you want to filter reminders by reminder date, select the **Narrow Result(s) By Due Date** checkbox and select the applicable date range.
6. If you want to include patients who have already been notified, select the **Include Patients Who Have Been Previously Notified** checkbox.
7. Select a **Method** of notification from the drop-down list.
8. If you want to filter reminders by notification date, select the **Narrow Result(s) By Date Notified** checkbox and select the applicable date range.
9. Click **OK**.

Notify	Name	e-mail Address	Notified	Method	SSN
<input type="checkbox"/>	ALEXANDER, EDWARD P				213-55-423
<input type="checkbox"/>	ALEXANDER, EVELYN L				647-09-762
<input type="checkbox"/>	ALEXANDER, MARIE D				213-56-421
<input type="checkbox"/>	ALEXANDER, SAMANTHA R				000-00-003
<input type="checkbox"/>	ALEXANDER, VIOLET W	violet@chcsii.com			202-45-574
<input type="checkbox"/>	BERG, LEE T				000-00-002
<input type="checkbox"/>	BERG, OLAF V	OLAF@CHCSII.COM			245-63-694
<input type="checkbox"/>	CHANG, ESTER M				788-27-904
<input type="checkbox"/>	CHANG, INDIRA L				000-00-002
<input type="checkbox"/>	CHANG, JON S	jon@chcsii.com			732-67-923
<input type="checkbox"/>	CHANG, MAMDOUH R				789-56-557
<input type="checkbox"/>	CLOUD, APRIL				000-00-002
<input type="checkbox"/>	CLOUD, HEATHER	heather@chcsii.com			645-21-005
<input type="checkbox"/>	CLOUD, LANCE				877-32-811
<input type="checkbox"/>	CLOUD, ROSE				536-65-211
<input type="checkbox"/>	MARCOS, FREDERICK B				532-97-362
<input type="checkbox"/>	MARCOS, RAMONA D	ramona@chcsii.com			013-97-987
<input type="checkbox"/>	SUAREZ, BONITA S	bonita@chcsii.com			000-00-002
<input type="checkbox"/>	SUAREZ, EDUARDO A	eduardo@chcsii.com			454-72-321
<input type="checkbox"/>	SUAREZ, JOSE Q				000-00-003
<input type="checkbox"/>	SUAREZ, MARIA E				626-78-443
<input type="checkbox"/>	SUAREZ, MIGUEL E				444-34-978
<input type="checkbox"/>	SUGARMAN, REGINALD T	reginald@chcsii.com			575-34-216
<input type="checkbox"/>	WILLIAMS, BERNICE K	bernice@chcsii.com			645-32-004
<input type="checkbox"/>	WILLIAMS, CLAYTON U	clayton@chcsii.com			967-62-886
<input type="checkbox"/>	WUNDERLICH, ANNA W	anna@chcsii.com			223-76-089
<input type="checkbox"/>	WUNDERLICH, GERTHA M				000-00-002

Figure 38-3: Screening Notifications

38.3 Notifying Patients about Screening Services

Patients listed in the Screening Notification module have a date in the corresponding wellness reminder column that determines when they need to be notified, either by e-mail, letter, or both.

Follow the steps below to notify patients about future screening services:

1. Select a patient(s) and double-click the **Notify** checkbox(es).
2. Click **Notify** on the Action bar to open the Notification Options window.
3. Select a notification option and click **OK**.
 - If you are notifying the patient by letter, the Print Preview window opens displaying a form letter for the patient you are notifying.

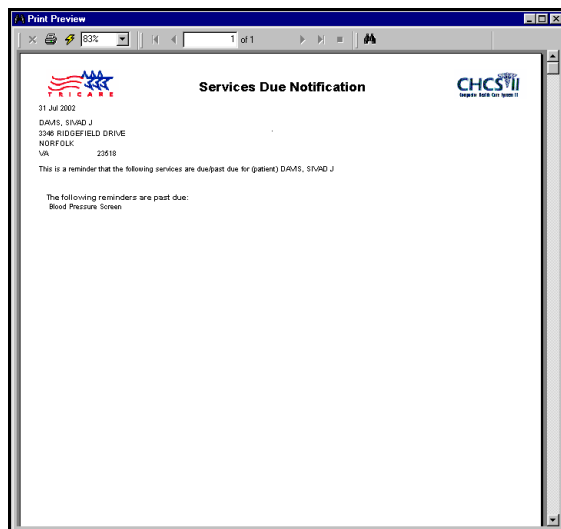


Figure 38-4: Print Preview Window

- Click the printer icon.
- On the Print window, click **OK**. The letter(s) is sent to your designated printer.
- If you are printing labels, a Notification Reminders window opens. Click **Yes** when you have manually loaded the printer with label-specific paper. Click **No** if you are not printing envelope labels.

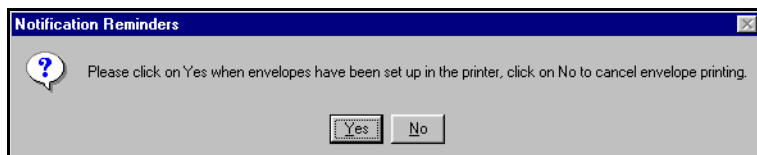


Figure 38-5: Notification Reminders Window

- If you are notifying the patient by e-mail, the E-Mail Notifications window opens. Click **Yes** to send the patient a form e-mail notifying him/her of the due screening service(s).

Note: The letter and e-mail notifications contain the same information, they are just sent using different methods.

Tip:
The patient's postal and e-mail addresses are maintained in the Demographics module and can be modified, if necessary.

39.0 SIGN ORDERS

39.1 Sign Orders Overview

The Sign Orders module allows you to validate orders submitted by non-providers. When a non-provider submits a consult, lab order, radiology procedure, or medication for a patient encounter in the A/P module, the assigned provider receives notification that an order was entered on your behalf by the non-provider. The order's status is pending until you sign the order.



Figure 39-1: Sign Orders Alert

39.2 Cancelling a Non-Provider Order

The Sign Orders module lets you cancel orders entered by non-providers in the A/P module.

Follow the steps below to cancel a non-provider order:

1. On the Sign Orders module, select the order(s) you want to cancel.
2. Click **Cancel Selected Orders**. A confirmation window appears.
3. Click **Yes**. The order(s) is removed from the Sign Orders module.

39.3 Signing Non-Provider Orders

The Sign Orders module allows you to validate orders entered by non-providers in the A/P module. You do not need to have the patient's encounter open to sign the order(s). The Sign Orders icon displays in the patient ID line when you have orders that need to be signed.

Follow the steps below to sign non-provider orders:

1. On the Sign Orders module, select the checkboxes for the order(s) you want to sign.
2. Click **Sign Selected Orders**. The order(s) is removed from the Sign Orders module.

Note: If you want to sign all orders listed, click **Sign All Orders**. If you want to view detailed information about the order, expand the order by clicking the small plus (+) next to the order. If you want to expand all orders in the workspace, click **Expand All**.

40.0 SUBJECTIVE/OBJECTIVE (S/O)

40.1 Subjective/Objective Overview

The S/O module is used to document the S/O portion of the note. Terms to describe the exam findings are available to select into the note. Each term is coded and those codes are one of the elements used to determine the E&M code in the Disposition module. Templates and AIM Forms are used to rapidly document the patient visit. Once the exam is documented and saved, the notes appear in the Encounter module.

The S/O module provides you with two different ways to document the encounter: with an S/O template or with an AIM (Alternate Input Method) Form. Each of these means enables you to document your findings with structured terms for a patient encounter and enables you to produce accurate and complete coding. Templates can be either user-created or provided with the system, while the forms are provided to each clinic and MTF by the appropriate service. In this chapter we cover using both templates and forms to document the S/O portion of an encounter.

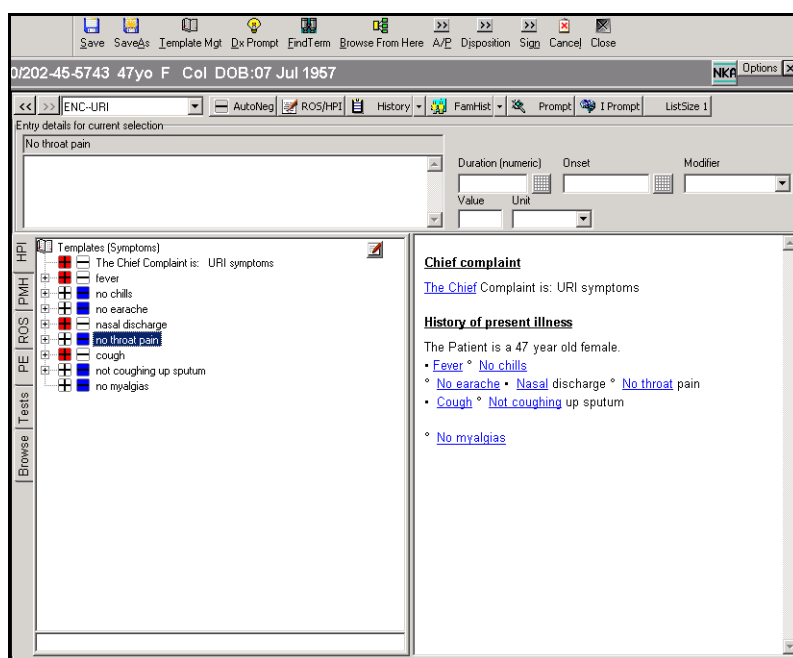


Figure 40–1: Military Clinical Desktop – Subjective/Objective Module

Note: The use of this software is not intended to suggest or replace any professional medical judgment, decisions, or actions with respect to a patient's medical care. The user of this software must monitor and verify the input to the software and determine the accuracy, completeness, or appropriateness of any diagnostic, clinical, or medical information, or other output provided by the software.

40.1.1 In More Depth: Navigating and Using S/O

To navigate and use the S/O module, you need to be comfortable with several key concepts.

40.1.1.1 Navigating within the Module

To navigate within the module, simply use the S/O module tabs located along the left margin of the workspace. These tabs correspond to the basic functional areas of S/O and the sections in the encounter document and note.

40.1.1.2 Adding Terms

To add a term to the note, simply select the large plus or minus sign. When selected, this sign becomes red (+) or blue (-). There are exceptions for more advanced users, but generally, adding a term as positive means that it is an abnormal finding and adding a term as a negative denotes a normal finding.

40.1.1.3 Using the S/O Toolbar (Dashboard)

The S/O toolbar is a sophisticated and essential component of S/O documentation. It enables you to add a range of detailed and explanatory information to any term you add. As you'll see in this lesson, selecting a term in the MEDCIN hierarchy populates the term in the dashboard.

This means that the dashboard is focused on that term. The various elements of the dashboard represent different functions for adding to or modifying the selected term.

We use this dashboard to add free-text to a note, document the duration of a condition, and specify a term as a family history term. And perhaps most importantly, in this lesson you learn how to use **AutoNeg** to rapidly document normal findings.

40.1.1.4 Using the Narrative Pane

To the right of the S/O module is the narrative pane, which displays the narrative for this encounter based on the terms selected and the modifiers added to these terms. The narrative as it appears in this pane, is identical to the narrative that appears in the encounter note.

In terms of an S/O workflow, these four key concepts work together to create an effective tool that is easy to use:

1. Use the tabs to get where you need to be.
2. Use the MEDCIN terms to document the patient visit.
3. Use the toolbar to add detailed and specific information to a selected term.
4. Use the narrative pane to see how your documentation is read in the encounter note.

40.2 S/O Templates Overview

Use of a template to document a patient visit is a key feature of CHCS II. Template use greatly streamlines the documentation process and ensures that coding is accurate and complete when the encounter is done.

A template pre-positions clinical terms for rapid entry and reflects how providers typically document encounters. If a template is created correctly, a provider should be able to, with minimal clicks, document a normal exam. Personal templates should be built and utilized to use the S/O module efficiently. Templates should match the common visit types you see and include terms from each of the following:

- **Physical Exam (PE):** A good PE section includes items that are typically reviewed for each physical exam.
- **Review of Systems (ROS):** Each provider has a list of questions that is asked of every patient in regards to the ROS. Therefore, the section should reflect those questions. A comprehensive ROS section can be included in a template with a large repository of findings to deal with “oh, by the way” situations.
- **Past Medical History (PMH):** The PMH section deals with common questions concerning previous hospitalizations and family and social history. Again, findings should be selected that reflect what is normally asked of the patient.
- **Procedure (PROC):** Procedure notes are blocks of free-text that cover routine procedure, education, and informed consent notes. These can be added using the free-text icon from the PE tab or by typing the free-text to an actual term (e.g., attaching a procedure note to the term *skin biopsy*).
- **History of Present Illness:** This section includes the chief complaint and common symptoms based on the theme of the template.

40.2.1 Putting It into Practice

When a patient has a common reason for an appointment, for example, asthma follow-up, the provider simply loads the Asthma Template that contains the appropriate terms (PE, ROS, PMH, PROC). If, in the process of the exam, the patient complains of a sore throat, the provider can load just the Sore Throat template to document the “oh, by the way” symptom.

40.2.2 Selecting an S/O Template

The most efficient way to document the S/O note is to use an S/O template that you have customized. Once a template is loaded, there are various approaches to document findings from certain tabs. Generally, positive or abnormal findings are documented first in order to capitalize on the AutoNeg function. This can be done on the HPI, ROS, and PE tabs.

Follow the steps below to select an S/O template:

1. Click **Template Mgt.** from the Action bar to view the S/O Template Management module.

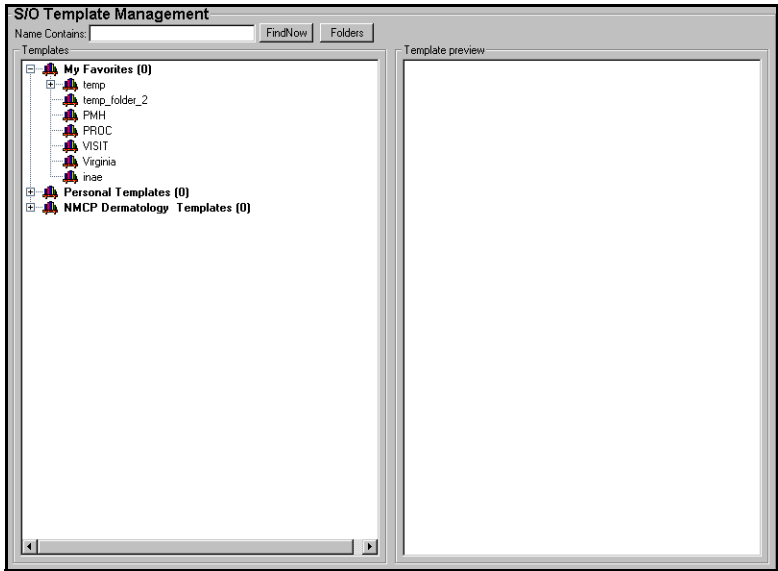




Figure 40–2: S/O Template Management Module

- 2. Search for the desired template by typing in the name or type of the template (URI, visit).
- 3. Click **Find Now** to view the templates that meet the search criteria.
- 4. Select the template and click **Load** on the Action bar.

Note: S/O templates are displayed with the  icon. The  icon delineates an S/O Form.

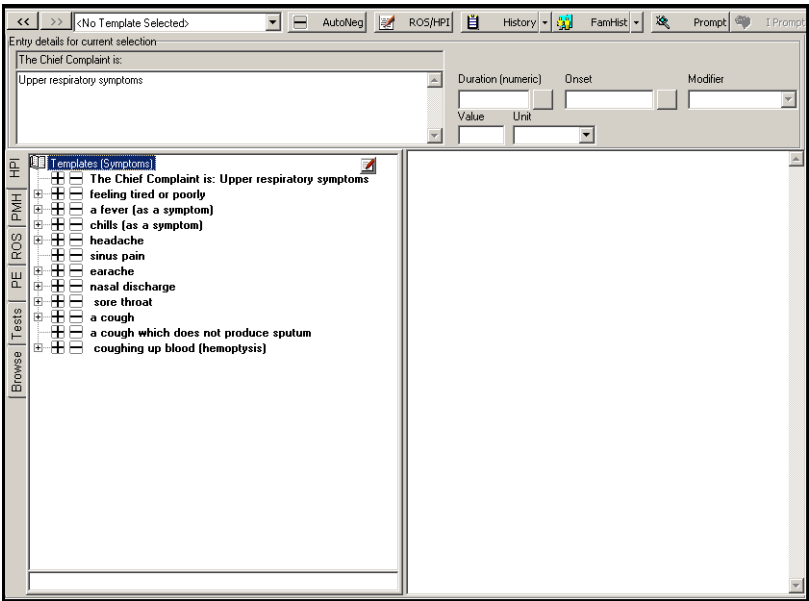


Figure 40–3: Loaded Template

- After a template is loaded, terms from the template are displayed on the appropriate tabs. If there is a small plus sign next to a parent term, click it to expand the list and view the associated children terms. A small minus sign indicates the term has been expanded completely.

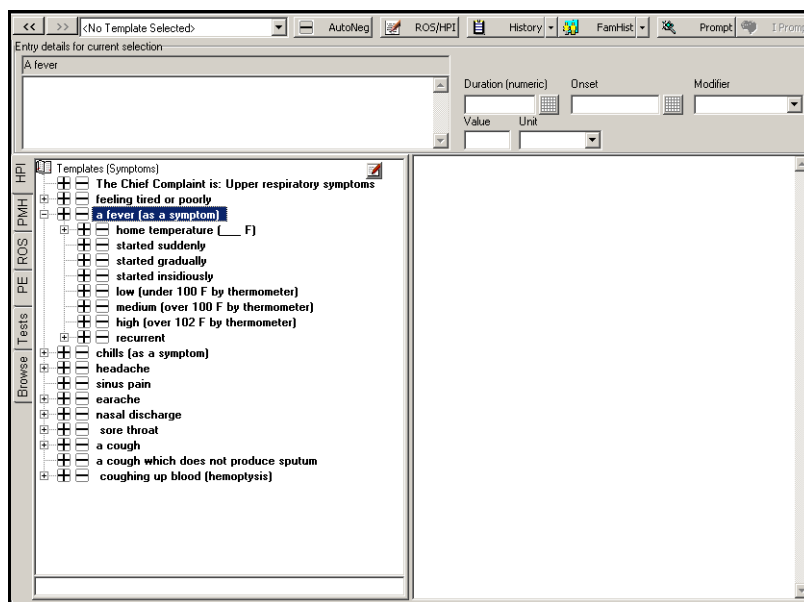


Figure 40–4: Parent/Child Relationship

40.2.3 Documenting from the HPI Tab

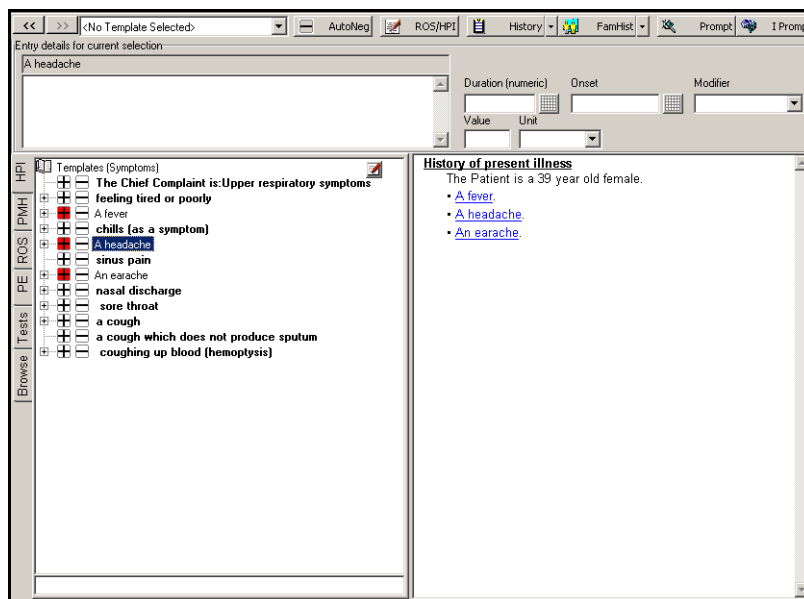


Figure 40–5: HPI Tab

Follow the steps below to document from the HPI tab:

1. Document all the positive or abnormal findings first by clicking the large plus sign next to the term. The selected terms are added to the Narrative pane under the History of Present Illness (HPI) heading.
2. Once all the positive or abnormal terms have been selected, click **AutoNeg** to document the rest of the terms as normal findings.

Note: One can document rapidly and accurately using the AutoNeg function. This is active only for the Symptoms, Review of Systems, and Physical Exam tabs. Clicking **AutoNeg** enters all the top-level, parent findings in the list as negative or normal. This is extremely helpful for physical exams and review of systems.

3. Click the opposite sign to change a finding. Click the sign that was selected to delete it.
4. If desired terms are not present on the template or the HPI needs to be characterized, a subjective free-text note can be added. Click the **Notepad** icon in the upper right corner of the findings list.
5. Enter the note.

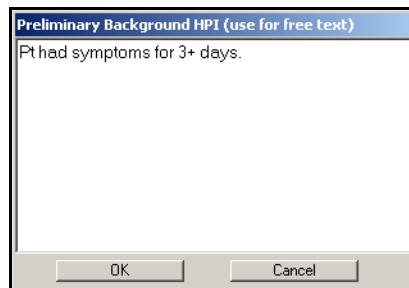


Figure 40-6: S/O Notepad

6. Click **OK** to add the note to the encounter.

40.2.4 Documenting from the PMH Tab

In order to document from the History (PMH) tab, simply add positive or negative responses to the terms by clicking the large plus or minus sign.

Note: The AutoNeg function cannot be used on the PMH tab.

Entry details for current selection:
No history of appendectomy

Duration (numeric) Onset Modifier

Value Unit

Templates (History)

- ☒ smoking
- ☒ family history of ACUTE MYOCARDIAL INFARCTION age 45 or earlier
- ☒ history of essential hypertension
- ☒ history of ASTHMA
- ☒ history of hypothyroidism
- ☒ history of DIABETES MELLITUS
- ☒ family history of LARGE INTESTINE NEOPLASM MALIGNANT
- ☒ No family history of malignant female breast neoplasm
- ☒ family history of OVARIAN NEOPLASM MALIGNANT
- ☒ history of Previous Balloon Angioplasty
- ☒ history of Coronary Artery Bypass Graft (CABG)
- ☒ No history of appendectomy
- ☒ history of Cholecystectomy

Chief complaint
The Chief Complaint is: Upper respiratory symptoms.

History of present illness
The Patient is a 39 year old female.

- A fever.
- A headache.
- A sore throat.

Past medical/surgical history

Diagnosis History:
Essential hypertension.
Hypothyroidism

Therapeutic History:
No appendectomy

Family history
No malignant female breast neoplasm

Figure 40-7: PMH Tab

40.2.5 Documenting from the ROS Tab

Entry details for current selection:
Chest pain or discomfort

Duration (numeric) Onset Modifier

Value Unit

Templates (Diagnoses, Syndromes And Conditions)

- ☒ No neck stiffness
- ☒ No lump or swelling in the neck
- ☒ Chest pain or discomfort
- ☒ No dyspnea
- ☒ No night sweats
- ☒ No wheezing

Chief complaint
The Chief Complaint is: Upper respiratory symptoms.

History of present illness
The Patient is a 39 year old female.

- A fever.
- A headache.
- A sore throat.

Past medical/surgical history

Diagnosis History:
Essential hypertension.
Hypothyroidism

Therapeutic History:
No appendectomy

Family history
No malignant female breast neoplasm.

Review of systems

Otolaryngeal symptoms: No neck stiffness and no lump or swelling in the neck.

Cardiovascular symptoms: Chest pain or discomfort.

Pulmonary symptoms: No dyspnea, no night sweats, and no wheezing.

Figure 40-8: ROS Tab

To document from the ROS tab, document the positive or abnormal findings first by clicking the large plus sign next to the term. Click **AutoNeg** to document the rest of the findings as normal. Be careful when using AutoNeg as all items must be discussed.

40.2.6 Documenting from the PE Tab

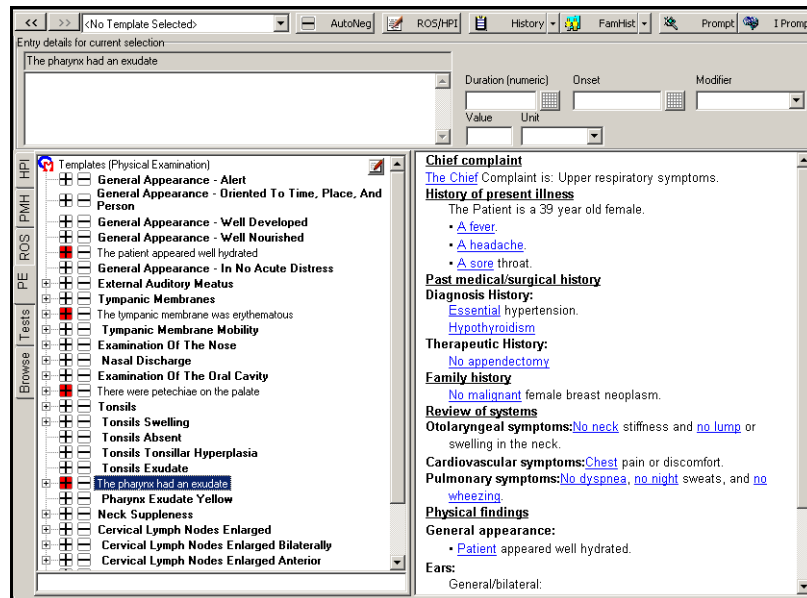


Figure 40–9: PE Tab

Follow the steps below to document from the PE tab:

1. Document all the positive or abnormal findings first by clicking the large plus sign next to the term.
2. Once all the positive or abnormal terms have been selected, click **AutoNeg** to document the rest of the terms as normal.

Note: The use of the AutoNeg function assumes the template has been customized to fit your workflow. If you own the template, the narration for normal findings is already known and can be added with confidence.

3. Once all findings are documented, click **Close** to save the note and return to the Encounter.

40.2.7 Adding Details to a Finding

Once a term has been selected from the findings list, it is displayed in the **Entry details for Current Selections** field and in the Narrative pane. Use the S/O Tool bar or the Dashboard to further explain the finding.

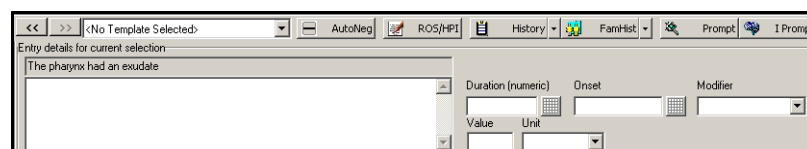


Figure 40–10: Toolbar and Dashboard

Follow the steps below to add details to a finding:

1. Select the term in the **Findings** list.
2. Select the desired detail or modifier:
 - **ROS (Review of Systems):** Flips the highlighted finding between the Review of Systems and History of Present Illness headings.
 - **History:** Sets the prefix to **History of**, then adds the current finding to the documentation.
 - **Family History:** Sets the prefix to **Family History of** then adds the current finding to the documentation.
 - **Entry Details for Current Selection Free-Text Field:** Enter in any additional information in the free-text field next to the **Entry Details For Current Selection** field and press **Enter**. The ellipse button displays the entire free-text field.
 - **Duration and Onset:** Click the **grid** to enter the associated date.
 - **Modifier and Unit:** Access the pull-down menus to add the adjective to the finding.
 - **Value:** Enter in the appropriate value.

Tip:

If the button is not appropriate for the selected finding, it is grayed out.

40.2.8 Using the Search Capabilities

Use one of the following tools to search for specific terms or to dynamically build a Visit template. Each tool is found on the Action bar.

40.2.8.1 Find Term

This feature searches for a term in the MEDCIN terminology. This conceptual search returns terms relevant to the search text regardless of spelling. Abbreviations such as HTN (hypertension) or CHF (congestive heart failure) are recognized.

1. Click **Find Term** from the Action bar to view the Search String window.

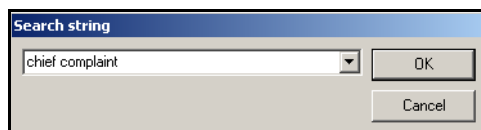


Figure 40–11: Find Term Search String

2. Enter the desired term and click **Search**.

40.2.8.2 Dx Prompt

This feature creates a list of findings based on one or more selected diagnoses. This is helpful when adding the history of present illness to a visit template or when building a visit template on the fly.

1. Click **Dx Prompt** from the Action bar to view the Search String window.



Figure 40-12: Dx Prompt Search String

2. In the Search String window, enter the diagnosis and click **Search**.
3. In the Select Diseases for Consideration window, select the appropriate disease and click **OK**. A template relevant to the term selected is displayed. Use the **List Size** button to control the number of terms on each tab.

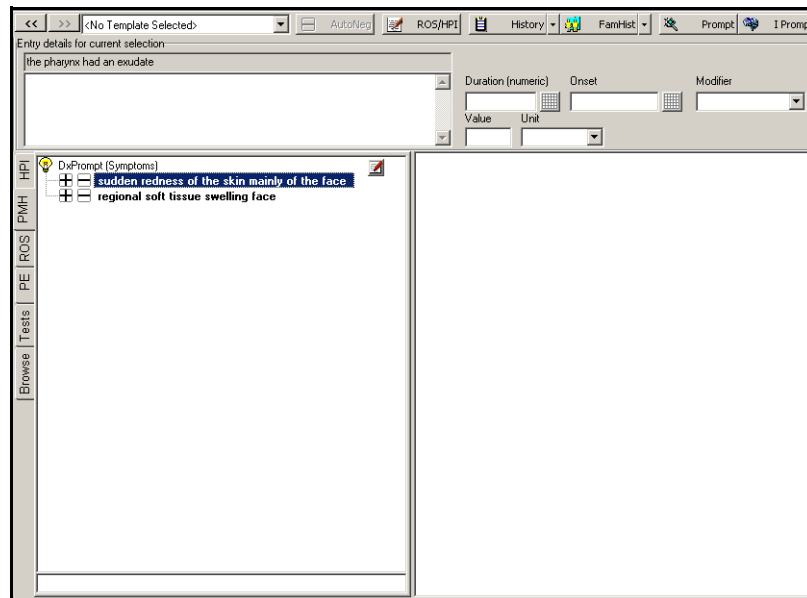


Figure 40-13: Select Diseases for Consideration

40.2.8.3 Prompt

This feature builds a finding list based on a single highlighted term.

1. Highlight a term from the Findings list.
2. Click **Prompt** on the S/O Tool bar.

Tip:

This tool is helpful for multi-symptom patients. You may want to see a list of relevant terms for consideration to help document the note.

40.2.8.4 I-Prompt (Intelligence Prompt)

This feature builds a list of terms based on the documentation in the Narrative pane. Once terms have been documented, click **I Prompt** on the S/O Tool bar to view a list of additional terms that might also be considered.

40.2.8.5 List Size

This feature creates a broader or narrower list of findings. Three levels exist: short (List Size 1), medium (List Size 2), and long (List Size 3). Use List Size after conducting a Find Term, Prompt, Dx Prompt or I Prompt.

40.2.8.6 Browse from Here

This feature displays the highlighted finding as it appears within the MEDCIN terminology. Related Findings can be seen and selected.

1. From the Findings list, select the term to be located.
2. Click **Browse from Here** on the Action bar.

Tip:
The Browse from Here function is helpful when locating PE terms.

40.2.9 Importing/Exporting an S/O Template

An S/O template can be imported or exported from other facilities using CHCS II.

Follow the steps below to export an S/O template:

1. From the S/O Template Management module, select the template to export.
2. Click **Export** from the Action bar to view the Export S/O List Template window.

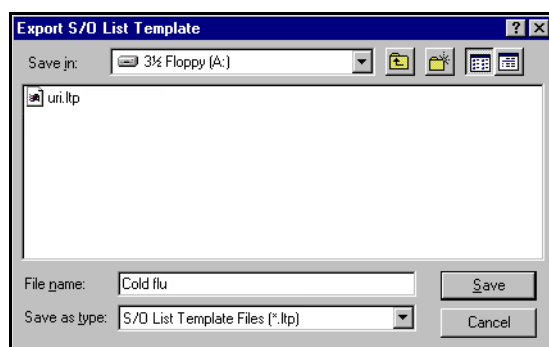


Figure 40-14: Export S/O List Template Window

3. Select the desired location for the template, type in the name of the template, and click **Save**.

Follow the steps below to export multiple templates:

1. Select the templates to export by holding down the **Ctrl** key.
2. Click **Export** from the Action bar to view the Select Export Path window.

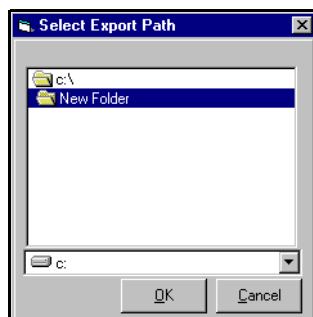


Figure 40-15: Select Export Path Window

3. Select the location for the exported templates and click **OK**.

Follow the steps below to import a template:

1. From the S/O Template Management module, click **Import** from the Action bar to view the Import MEDCIN Template window.

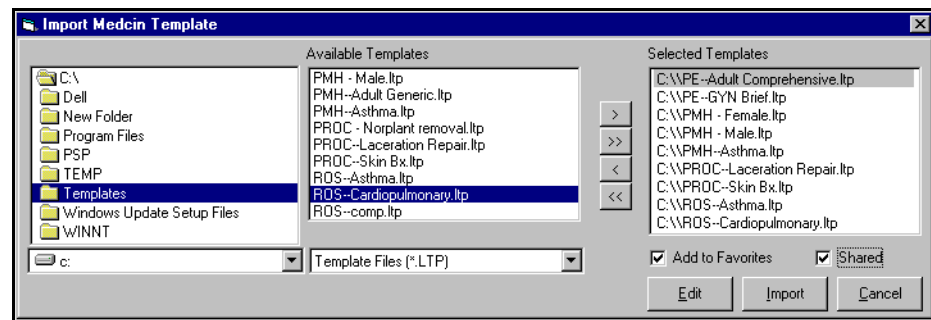


Figure 40–16: Import MEDCIN Template Window

2. In the left pane, navigate to the location of the template(s). Once the location is determined, the available templates are displayed.
3. Select the template(s) to be imported and use the arrow keys to move the templates to the Selected Templates column.
4. Click **Import** to save the template(s) as is. Click **Edit** to open the template in Template Edit mode to add or remove terms prior to saving.

Note: If a template currently exists with the same name as a template being imported, a message is displayed asking whether or not to override the existing template.

40.3 S/O Template Personalization Overview

CHCS II contains a list of common templates as a starting point. Though these are helpful, there will be times when clinicians need to customize their own templates to optimize the use of the application in clinical practice. Templates are the key to rapid documentation and accurate coding.

The first step to creating a useful set of templates is to review the templates that currently exist. Each service has created their own set of templates that have been reviewed. Identify the templates that fit with your documentation style and physical exams for the most common visit types you see. Once identified, use these templates as you see patients to become familiar with the terms on the template as well as the terms that are not on the template.

As you begin to familiarize yourself with the templates, you may notice that some templates do not exactly meet your documentation style. This is where the personalization comes in. Each template can be edited to match your personal style.

This section will cover the key skills needed when editing a template.

40.3.1 Editing a Template

A template can be edited using Template Edit mode. It allows for quick addition or removal of terms as well as easy merging of component templates.

Follow the steps below to edit a template:

1. From the S/O Template Management module, import the VISIT--URI Brief template provided by your instructor.
2. Highlight the template and click **Edit** from the Action bar to view the template in Edit Mode.

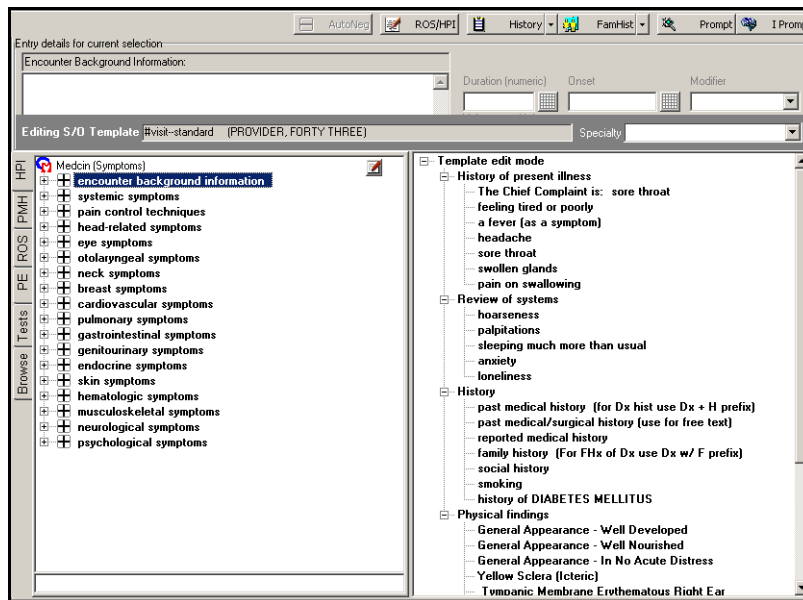


Figure 40–17: Template Edit Mode

40.3.1.1 Removing Terms from the Template

In this scenario remove the following terms:

- nasal passage blockage (stiffness)
- skin symptoms
- yellow sclera (icterus)

To remove terms from the template:

1. Locate and select nasal passage blockage from the template outline. The finding is displayed in the findings list on the left.
2. Select the plus sign in the MEDCIN tree to remove the finding.
3. Complete the steps above to remove the two other findings.

New findings can be added by using one of the search capabilities to locate and select the finding. Once selected, the new term is added to the outline on the right. We will look at these search capabilities as they are used to add terms to the different sections of the template.

40.3.2 Personalizing the Physical Exam Section

When personalizing any PE section of a template, keep in mind the AutoNeg function. If a template is built correctly, documentation of a normal PE can be done by clicking **AutoNeg**.

Because so much of your physical exams are normal, the AutoNeg capability is especially well suited to this section--as is the approach we teach here—the approach of **documenting by exception**.

As we discussed earlier, **AutoNeg** enables you to automatically—and with a single click—document all normal findings from a template.

In this lesson, we cover several key concepts. These concepts are key to understanding how to add terms to the PE section and are discussed in more detail later in this lesson.

- **Bilateral structures.** Bilateral structures are the two sides or halves of the same organ—in this lesson, the right and left ears. Adding bilateral structures enables you to document that you checked both parts of the structure. In this case, our template lets us document that we checked both tympanic membranes for erythema.
- **Common positives.** Common positives are terms contained within a parent term that you commonly find as abnormal findings with your patients. Adding common positives enables you to document frequently abnormal findings while still using a parent term to document the normal finding.
- **Free-text added to a Term:** Free-text can be added to an individual finding for clarification. For example, if the finding 'Lymph Node: Normal' needs to be clarified to state there are no nodules present, highlight the finding Lymph Nodes: Normal and enter the desired text in the free-text field in the dashboard. Press **Enter** to add the note to the Narrative pane.

40.3.2.1 Setting the Scene

In this demonstration, we build a PE template for a routine URI exam.

In our routine physical exam, we normally:

- Examine the left and right tympanic membranes for erythema
- Check for nasal discharge and frequently find either mucoid or purulent discharge
- Examine the neck, and, if normal, we qualify normal by writing: *neck: normal with no thyromegaly*.

40.3.2.2 Adding Bilateral Structures

Now let's continue personalizing our template by adding our routine exam of the left and right tympanic membranes for erythema.

To add these terms, we use the skill of adding bilateral structures. We use this skill when we want to document two sides or halves of the same organ—in this case, the right and left ears.

To add this bilateral structure, we use a basic search capability of MEDCIN—the Browse from Here feature. This feature enables you to search through the MEDCIN hierarchy to find the terms you want.

When displayed with this feature, the MEDCIN hierarchy is organized by organ system—so we'll be exploring the Ears term to find the terms we want.

To add bilateral structures:

1. With the template in Template Edit mode, select the **Nasal Discharge** term from the outline and click **Browse from Here** in the Action bar. The MEDCIN hierarchy appears in the left pane of the workspace.
2. Now, we close the **Nose** term and expand the **Ears** term, then navigate to the **Tympanic Membrane** term and open it.
3. The **Tympanic Membrane** term contains an **Erythematous** term, so we open it.
4. We're now ready to add our **bilateral structures**—as this term contains both right and left ears as terms. So we select both terms to add to the template.

Note: Adding bilateral structures enables you to document that you checked both parts of the structure. In this case, our template lets us document that we checked both tympanic membranes for erythema.

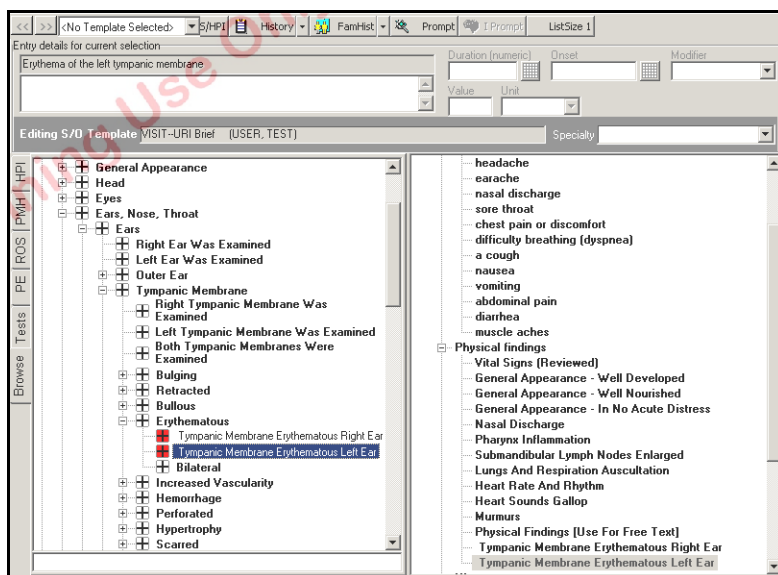


Figure 40–18: Bilateral Structures

40.3.2.3 Adding Common Positives

The second part of our physical exam for a URI patient is our examination for nasal discharge.

We want our template to reflect that we examine the patient for nasal discharge, and, more specifically, we frequently find either purulent or mucoid nasal discharge.

We want our template to enable us to document that we examined the patient for nasal discharge and to identify, if applicable, the type of discharge we find.

To do this, we use the skill of adding common positives to add the general nasal discharge term as well as the more specific mucoid and purulent discharge terms.

To add common positives:

1. Start by opening the Nose term. We can see that **Nasal Discharge** is available as one of its children terms and is already part of the template.
2. Since we also want more specific terms in our template, we open the **Nasal Discharge** term and see both **Mucoid** and **Purulent** as children.
3. Those are the two terms we want, so select both terms.

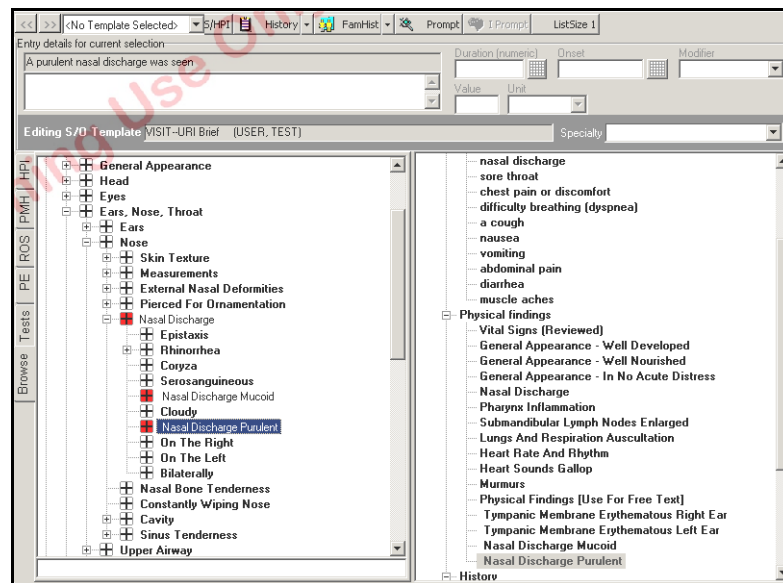


Figure 40–19: Adding Common Positives

40.3.2.4 Why Add Common Positives?

Adding common positives enables you to document frequently abnormal findings while still using a parent term to document the normal finding.

Now, when I'm using this template for a patient with a normal finding, **Nasal Discharge** is added as a normal finding when we click **AutoNeg**.

But, for a patient where we find one of these types of discharge, we can manually add the common positive to document the specific type of discharge.

This is the value of embedding common positives in your template—cover a normal finding with the parent term yet have the flexibility, with an abnormal finding, to be specific about the findings.

40.3.2.5 Adding Free-Text to a Term

The final skill we use in the PE section is *adding free-text to a term*.

This skill is used when you cannot find an exact match for how you write a note—and you want to essentially customize an existing term to reflect your documentation style.

In this demonstration, add free-text to a term so the template reflects the current note, written for a normal neck exam—*neck: normal, supple with no thyromegaly*.

To add free-text to a term:

1. Let's start by opening the **Neck** term. With the term open, we don't see an available term that matches our written note.
2. Now, to add a customized term, start by adding **Neck** as a negative finding. The term populates the details section at the top of the workspace.
3. In the associated details field, enter the free-text note: (*supple with no thyromegaly*). We enter this free-text in parentheses so we can differentiate it from the structured term in the note.
4. Press **Enter** on the keyboard.
5. We can see the free-text note in the narrative pane.
6. Now, in our physical exam, if a patient has a normal neck finding, clicking **AutoNeg** populates the narrative pane with our normal note.

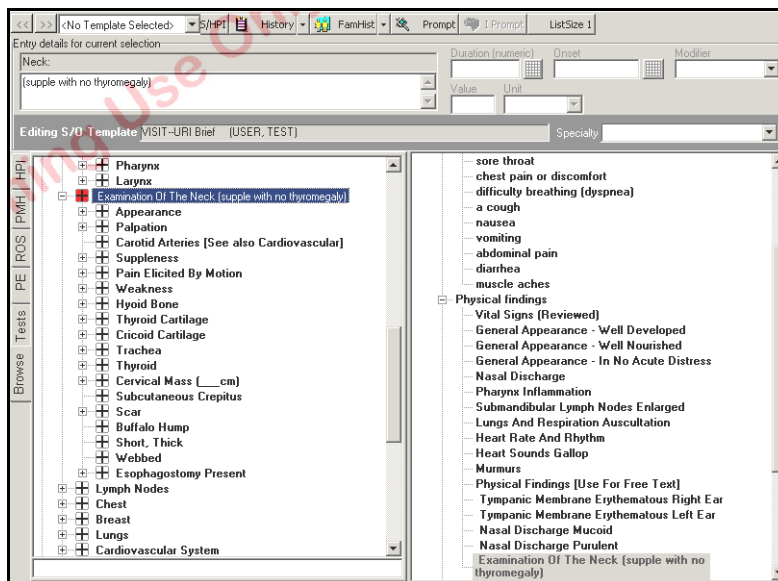


Figure 40–20: Adding Free Text

40.3.3 Personalizing the ROS and HPI Sections

The ROS and HPI sections of the template are both made up of symptoms so they use the same portion of the MEDCIN tree, the Symptoms. One symptom cannot be in both sections so providers routinely decide which terms should be in the ROS section and which terms should be in the HPI. Because the two areas use the same term set, this lesson will focus on the skills needed to add terms to both sections.

In this lesson, we cover several key template-editing skills, including:

- Use Find Term to locate terms in MEDCIN

- Use the ROS/HPI Button when ROS term is HPI
- Use the Prompt to locate terms
- Use List Size to expand the search
- Use the Dx Prompt to locate terms

These concepts are key to understanding how to edit templates and are discussed in more detail later in this lesson.

- **FindTerm:** This feature, available in the S/O action bar, enables you to search for terms directly in the MEDCIN hierarchy. In this lesson we show you how to find dizziness in the MEDCIN hierarchy.
- **Prompt:** This feature uses the term you select in the MEDCIN hierarchy—*dizziness* in this case—as the search value and returns terms related conceptually to that term. To use this feature, which is available in the S/O dashboard, select the term you want, then click **Prompt**. The conceptual matches populate the workspace.
- **List Size:** By design, CHCS II displays a limited set of search results--the most likely relevant results based on the diagnosis you searched for. The ListSize button, available in the dashboard, enables you to view these longer lists of terms.
- **Dx Prompt:** This feature allows you to search for a list of terms that are conceptually related to a specific diagnosis. Be careful with this search - it only works with a diagnosis as the search value.

40.3.3.1 Setting the Scene: Symptom

We are building this template to cover our standard terms for a patient complaining of dizziness, UIR symptoms, and pharyngitis, so we will add terms relative to each theme.

In our ROS, we ask the patient about several symptoms, including:

- Dizziness
- Palpitations
- Fainting
- Disorientation

In the HPI, we want the following symptoms:

- Headaches
- Swollen glands in the neck
- Difficulty swallowing

To edit the template:

1. In the Action bar, click **Find Term**. Find Term enables us to search for dizziness as a term as we begin building our template.
2. In the search window, enter *dizziness* and click **Search**. We are returned to the HPI tab of the S/O module.

3. Click **ROS** because that is where we want to term to be located.
4. Start by adding **Dizziness** to the template. The Find Term feature did not return the rest of the terms we want for this template.

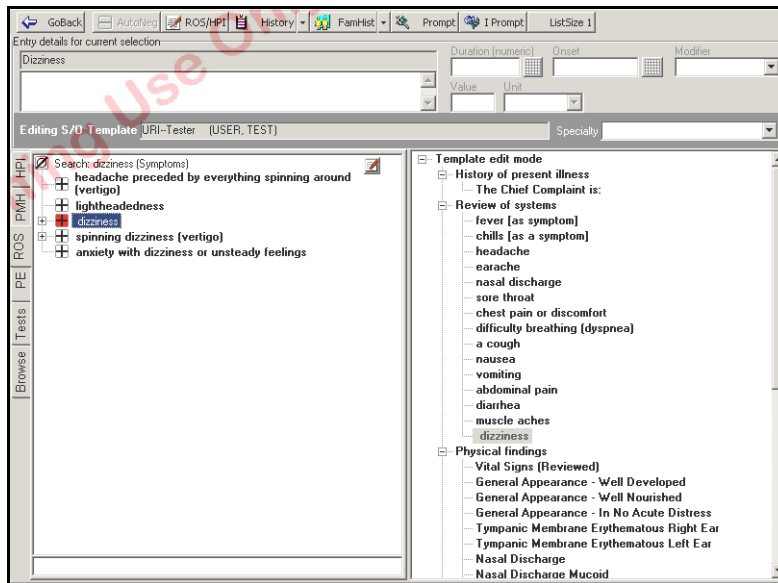


Figure 40–21: ROS Tab

5. We're now going to use another search feature—the **Prompt** feature. This feature uses the term you select in the MEDCIN hierarchy—*dizziness* in this case—as the search value and returns terms related conceptually to that term.
6. To use this feature, with dizziness selected, click **Prompt** in the Dashboard.
7. The Prompt feature returns the terms related to our search value, but we have to click **ROS** to return to the tab we want.
8. You can see two of the terms we want—**Palpitations** and **Fainting**—so add both terms.
9. The search results, though, don't include the last term we want to add. To find this term, click **List Size** in the Action bar, to expand the search.
10. Complete the ROS section by adding **Disorientation**.
11. The first term to be added to the HPI section is Headaches. This term is already in the template but under the ROS section. To move it to the HPI section, select the term from the template outline.
12. Click ROS/HPI from the Dashboard. The term *headache* moves to the HPI section.
13. There are two more terms to locate for the HPI section. Because we are looking to include terms related to pharyngitis, we can use the Dx Prompt. Click Dx Prompt in the Action bar.
14. In the search field, enter *pharyngitis* and click **OK**.
15. In the Select Disease for Consideration window, select pharyngitis and click **OK**. The MEDCIN tree is populated with terms related to the specified diagnosis.

16. Now we can add the last two terms, *swollen glands in the neck* and *difficulty swallowing*.

40.3.3.2 Personalizing the PHM Section

In this lesson, you learn the concepts and skills associated with building a PMH template. The PMH section deal with common questions concerning previous hospitalizations, family, and social history.

Again, findings should be selected that reflect what the provider normally asks the patient.

In this lesson, we cover several key concepts. These concepts are key to understanding how to build PMH templates and are discussed in more detail later in this lesson.

Anchor terms. Anchor terms are high-level terms that correspond with the different types of PMH information you can collect. They are a crucial part of any PMH template—they enable you to document PMH findings not already covered by your template, as you can add free-text to each of these terms to document the unforeseen finding.

FindTerm. One of S/O's basic search features, this enables you to search the database of MEDCIN terms. In this lesson, we show you how this search returns the terms you want by including them in more general terms or nodes.

40.3.3.3 Setting the Scene

To build this template, we start by adding the template's anchor-terms. These anchor terms--Past Medical History, Family Medical History (reported), and Social History--are simply terms that indicate the type of finding and enable you to add more detail by adding free-text to the anchor.

For example, you can use the Family Medical History term to document a patient's family history for which you don't have the appropriate term included in your template.

Including anchor terms enables you to document a patient answer or finding that is not explicitly covered by a term included in the template.

With our anchor terms added to the template, we now move on to use the FindTerm feature to find and add different types of PMH terms.

To build our template, we add terms for:

- a social history of cigarette smoking
- a personal history of hypertension
- a family history of colon cancer
- a procedure history of tonsillectomy to our template.

These terms reflect common types of PMH questions.

To build our PMH template, we employ several key skills:

- using the two hidden MEDCIN nodes to locate diagnosis and procedure terms

- using the dashboard to add prefixes to a term
- using FindTerm feature to locate PMH terms

40.3.3.4 Adding Anchor Terms

When you personalize PMH sections, start by adding your anchor terms. By adding these anchor terms, you allow for the flexibility to document any PMH finding not included in your template—simply add the anchor term, then add free-text to the anchor to document the condition.

To add our anchor terms:

1. The first step is to navigate to the History section of the MEDCIN tree. The easiest way to do this is by clicking the **Browse** tab and expanding **History**.
2. Expand Past Medical History and add Medical and Surgical / Procedural, Family Medical History (reported), and Social History to the template.

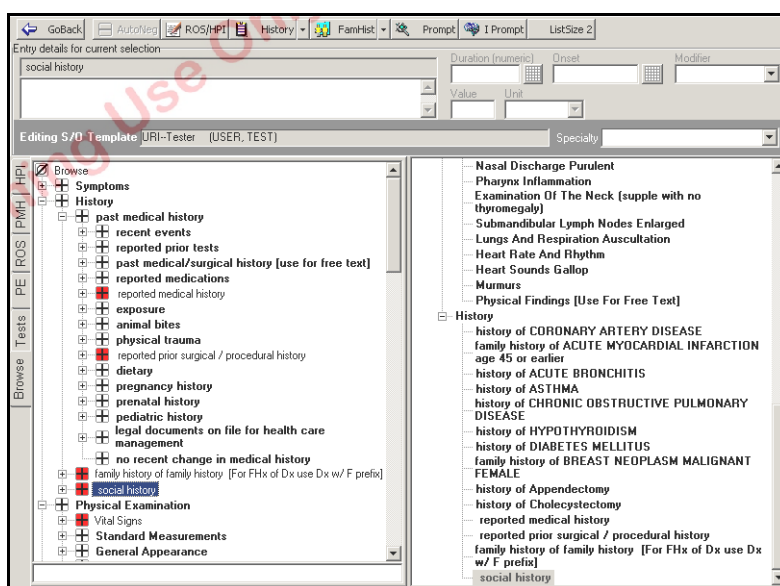


Figure 40–22: PMH Tab

3. With our anchor terms added, we're now ready to add the rest of our terms to this template.

40.3.3.5 Using Find Term

Though we've covered the Find Term search in previous lessons, there are several distinctive features when used to add to this section.

In this lesson, we use FindTerm for:

- a social history search
- a diagnosis search
- a family history search

- a procedure search

40.3.3.6 Social History Search

For our social history search, we want to add *cigarette smoking* to our template. To locate this term we use the Find Term feature.

To find a social history term:

1. Click **Find Term** and search for *cigarette smoking*. The search results populate the left pane.
2. Click the PMH tab and add **Smoking Cigarettes**.

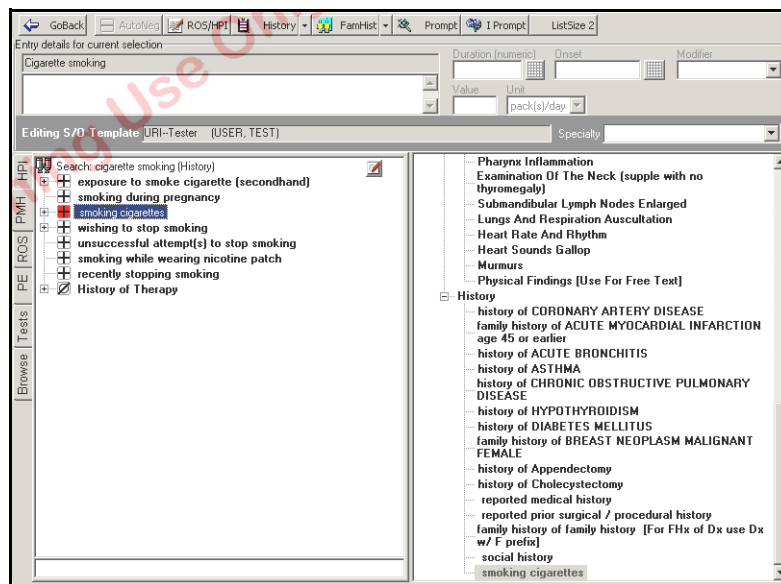


Figure 40–23: PMH Tab

40.3.3.7 Diagnosis Search

For our diagnosis search, let's add hypertension to our template. Again, we use the Find Term feature to locate this term.

To find a diagnosis term:

1. Click **Find Term**, and then search for *hypertension*. The search results populate the left pane, but we don't see hypertension in the results.
2. We don't see hypertension because, with the Find Term feature, diagnoses terms are located in the **History of Diagnoses, Syndromes, and Conditions** term—so we open the term.
3. We now see **Hypertension**, so add it to the template.

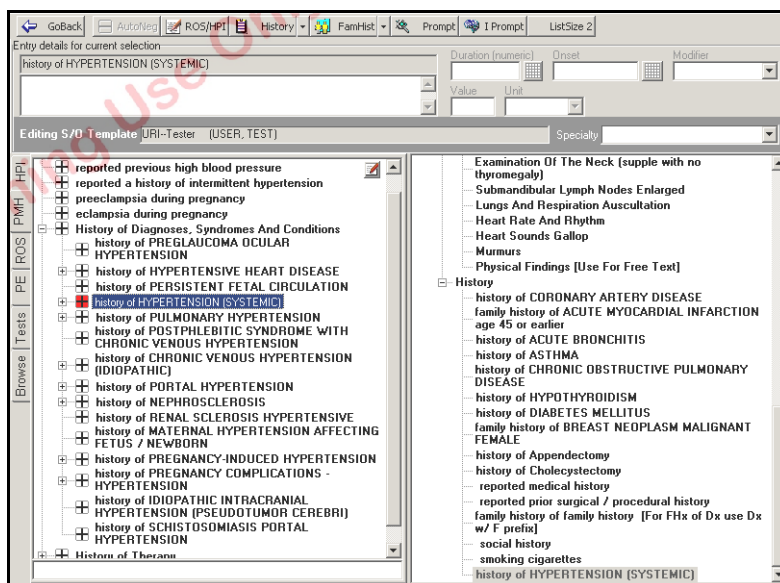


Figure 40–24: PMH Tab

40.3.3.8 Family History Search

For our family history search, let's add *colon cancer* to our template. Again, we use the FindTerm feature to locate this term.

To find a family history term:

1. With the PMH tab displayed, click **Find Term**, then search for *colon cancer*. The **search results** populate the left pane, but we don't see *colon cancer* in the results.
2. Again, like the diagnosis search, terms for a family history search are contained within the parent term **History of Diagnoses, Syndromes, and Conditions**—so we open the term.
3. Colon cancer doesn't appear verbatim, but History of Large Intestine Neoplasm Malignant does appear. This is because MEDCIN sometimes uses language and terms from the World Health Organization for some of its conditions. Now, simply add the term as a positive finding.
4. Because we want this term as a family history term, we need to define it as a family history term—so we click **FamHist**.

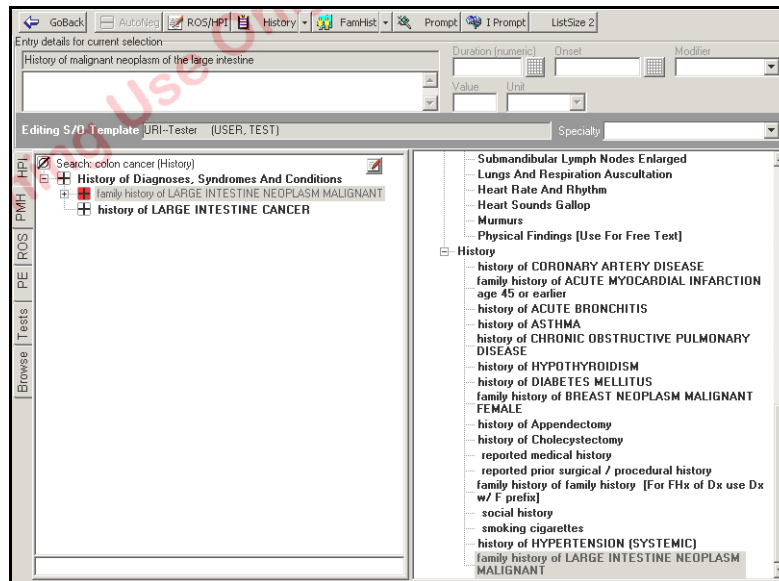


Figure 40–25: PMH Tab

40.3.3.9 Procedure Search

For our procedure search, let's add *tonsillectomy* to our template. Again, we use the Find Term feature to locate this term.

1. With the PMH tab displayed, click **Find Term**, then search for *tonsillectomy*. The **search results** populate the left pane, but we don't see *tonsillectomy* in the results—but we do see a **History of Therapy** term.
2. So open the term and see the search term.
3. Add **History of Tonsillectomy**.

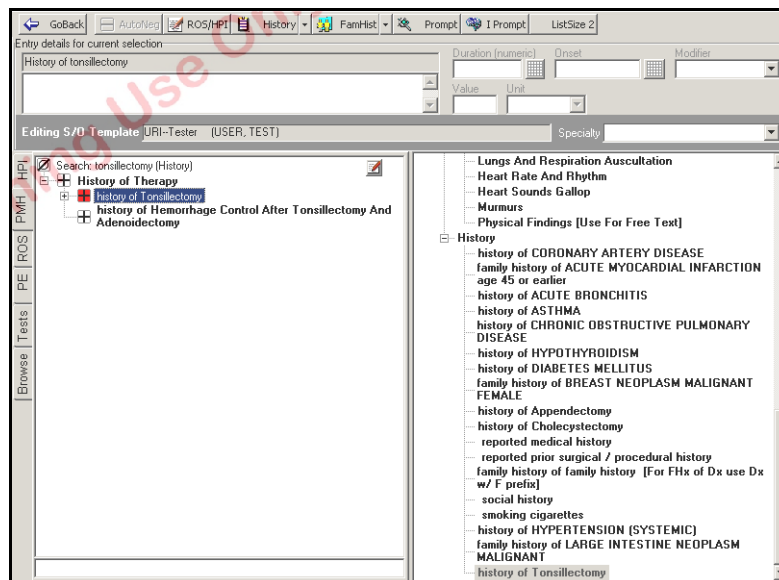


Figure 40–26: PMH Tab

40.3.4 Saving the Template

1. When all findings are included in the template, click **Save As** from the Action bar to view the Save List Note Template window.

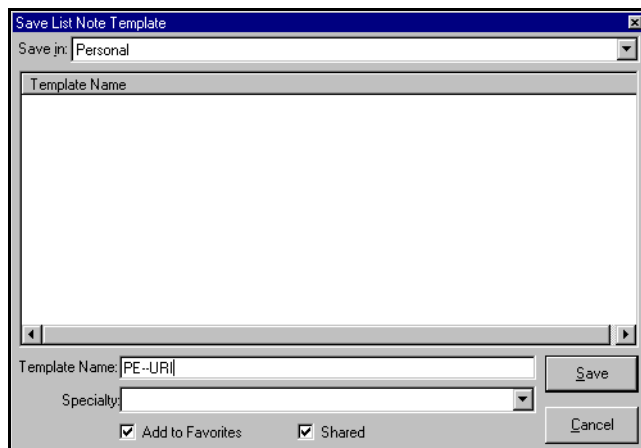


Figure 40–27: Save List Note Template Window

2. On the Save List Note Template window, enter the name of the template using the convention ‘VISIT--theme--[name].’ This organizes the templates together so they can be easily found.
3. The template is automatically added to your Favorites List (unless the checkbox is deselected). Select the **Shared** checkbox to make your template available to other clinical team members.
4. Click **Save** to save the template. **Cancel** closes the module without saving the template.
5. In order to test the template, load it into the encounter, click each tab, and practice using a patient scenario. On the PE tab, simply click **AutoNeg**. The resulting note should display an accurate narrative for a normal exam. Those findings that are not selected should be the findings that are used to document any abnormalities. When using this template to see patients, document the abnormalities first and then click **AutoNeg** to denote all other findings as normal.

Figure 40–28: Personalized Template

40.3.5 Creating a Free Text Template

A free text template can be used for routine procedure, education, and informed consent notes.

Follow the steps below to build a free text template:

1. Click the PE tab and click **Notepad** to open the free text window.

Figure 40–29: Free-Text Window

2. Enter the first words of the note the category of the template (e.g., “Procedure Note:” or “Education Note:”).
3. Enter the rest of the free text.
4. Click **Save and Close**. The note is added to the Narrative pane.

- Click **Save As** from the Action bar and name the template “PROC--[name]” or “EDU--[name]” as appropriate.

Note: A free text note can also be attached to a structured test term. Highlight the desired term (e.g., Skin biopsy) and add the procedure in the free-text field in the Dashboard. Press **Enter**, then save the template.

- Test the use of this template by loading it into an encounter. Remember to look on the PE tab for the procedure note.

Figure 40–30: Procedure Note

40.4 MEDCIN Forms Overview

The MEDCIN Forms provide you with easy-to-use tools and a library of service-provided forms that enable you to document the S/O section of the patient encounter. MEDCIN has over 250,000 clinical terms, subsets of which are grouped together in a form. Each form is built around a theme, a diagnosis or a symptom.

These forms were created and approved by Tri-service clinical consultants. These consultants are collaborating to create a standard library of forms to be used DoD-wide. MEDCIN Forms are an easy, streamlined way to complete the S/O documentation for an encounter. You can think of MEDCIN Forms as an electronic version of paper-based overprints, helping to ease the transition from paper-based medical records to electronic medical records.

Although in many ways forms and templates are simply two alternative ways of documenting S/O, there is a major difference that can help you determine which means to use. The forms provided by the system cannot be edited or modified, which means you are unable to customize a form to reflect your documentation style. If your style

matches the form provided, forms can be a very easy, streamlined way to complete the S/O documentation for an encounter.

The screenshot displays the MEDCIN Forms Tool interface. At the top, there is a menu bar with options: Save, Save As, Template Mgt, Dx Prompt, End Term, Browse From Here, A/P, Disposition, Sign, Cancel, and Close. Below the menu bar, a patient identifier is shown: 0/202-45-5743 47yo F Col DOB:07 Jul 1957. The main area is divided into several sections:

- Chief Complaint / Purpose of Visit:** Includes checkboxes for 'Women's Health Visit' and 'Reason for Visit is Deployment Related'.
- History of Present Illness:** Includes fields for 'Age at Menarche: (years old)', 'Age at Menopause:', 'Date of Last Menstrual Period: (Onset)', 'Menstrual Bleeding Lasts: (days)', and checkboxes for 'Severe Menstrual Pain', 'Less Menstrual Bleeding', 'Excessive Menstrual Bleeding', 'Bleeding Between Periods', and 'Vaginal Discharge'. There is also a text area for 'Additional History of Present Illness:'.
- Past Medical/Surgical History (Continued):** Includes checkboxes for 'Risk Factors?', 'Exposure Hx', 'DES Exposure', 'STD Exposure', 'Trauma Hx', 'Surgical Hx', 'Pregnancy Hx', and 'Dietary Hx'. There is also a text area for 'Additional Past Medical/Surgical History:'.
- Previous Therapies:** Includes checkboxes for 'Breast Surgery', 'GYN Surgery', 'Hysterectomy', 'Tubal Ligation', and 'OB Surgery'.
- Personal History:** Includes checkboxes for 'Caffeine Use', 'Tobacco Use', 'Alcohol Use', 'Herbals', 'Reg. Exercise', and 'Birth Control?'.
- Family History:** Includes checkboxes for 'Breast Ca', 'Ovarian Ca', and 'Uterine Ca'.
- Review of Systems:** Includes checkboxes for 'Pain During Urination (Dysuria)' and 'Pain During Intercourse'. There is also a text area for 'Additional Review of Systems:'.
- Past Medical/Surgical History:** Includes checkboxes for 'Prior Tests', 'Medication Hx', 'Admissions', 'ER Visits', and 'Medical Hx'.
- Previous Diagnoses:** Includes checkboxes for 'Hypertension', 'Thrombus', 'Liver Ds', 'Gallbladder Ds', 'Vaginitis', 'Diabetes', 'Migraine HA', 'Epilepsy', 'Fibromyalgia', 'Depression', 'PID', and 'Cancer'.

Figure 40-31: Military Clinical Desktop—MEDCIN Forms Tool

40.4.1 Loading a Form

To use a form to document the S/O portion of an encounter, you can either load the form from the Quick-Load list or you can click **Template Mgt.** on the Action bar and load the form there.

Follow the steps below to load with the Quick-Load menu:

1. In the encounter document, click **S/O**. The S/O module opens.
2. Display the Quick-Load menu by clicking the small **down-arrow**. The menu appears.
3. Scroll through the menu to the form you want, then select it. The form populates the workspace.

Note: All forms in the Quick-Load menu begin with AIM; Alternative Input Method.

Figure 40–32: Military Clinical Desktop—Quick-Load List

Follow the steps below to load a form from S/O Template Management:

1. Click **Template Mgt** from the Action bar to open the S/O Template Management module.

Note: Forms are represented by the  icon.

Figure 40–33: S/O Template Management Module

2. Enter the name of the form in the Search field.
3. Click **Find Now** to view the forms that meet the search criteria.
4. Select the form and click **Load** on the Action bar.
5. After a form is loaded, it populates the S/O module.

40.4.2 Navigating a Form

Navigation in MEDCIN Forms is similar to the other modules in CHCS II. Use the Action bar to perform basic actions in the MEDCIN Forms workspace. In addition to the Action bar, you can also use the Forms Toolbar and Tabs to navigate within the workspace.

40.4.2.1 Forms Toolbar

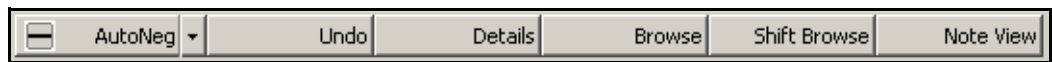


Figure 40–34: Forms Toolbar

The Forms Toolbar is located at the top of the workspace and provides you with form-specific functionality. This toolbar only appears when you have loaded a form and the form populates the workspace. The toolbar contains six options.

These options are as follows:

- **AutoNeg:** AutoNeg enables you to document all currently undocumented HPI or ROS findings as False or to document that the patient denied the symptoms. On the PE tab, it documents the statements as True or clinically normal. It is also a dual-purpose option that enables you to automatically select all positive or all negative values for a displayed form page. In order use this option, simply click the **arrow** to the right of the option, then select either **AutoPos** or **AutoNeg**. Selecting one of the options populates the form with the type of value you chose.
- **Undo:** This option enables you to undo your last actions. If you just selected a single item, clicking this option undoes that single action. If you have just clicked **AutoNeg** or **AutoPos**, this option undoes that action completely, returning the form to the previous state.
- **Details:** Clicking this button displays the Details pane in the bottom of the workspace. In this pane you can add more detailed information for the finding selected in the forms. In order to select a finding, single-click the finding you want, then click **Details**.

0202-45-5743 47yo F Col DOB:07 Jul 1957

AIM - Well Woman Exam AutoNeg Undo Details Browse Shift Browse Note View

History Physical Exam Help Outline View

Chief Complaint / Purpose of Visit

☐ Women's Health Visit

☐ Reason for Visit is Deployment Related

History of Present Illness

Age at Menarche: (years old)

Age at Menopause:

Date of Last Menstrual Period: Onset

Menstrual Bleeding Lasts: (days)

☐ Severe Menstrual Pain

☐ Less Menstrual Bleeding

☐ Excessive Menstrual Bleeding

☐ Bleeding Between Periods

☐ Vaginal Discharge

Additional History of Present Illness:

Past Medical/Surgical History (Continued)

Risk Factors? ☐ ☐

Exposure Hx ☐ ☐

DES Exposure ☐ ☐

STD Exposure ☐ ☐

Trauma Hx ☐ ☐

Surgical Hx ☐ ☐

Pregnancy Hx ☐ ☐

Dietary Hx ☐ ☐

Additional Past Medical/Surgical History:

Previous Diagnoses

Hypertension ☐ ☐

Thrombus ☐ ☐

Liver Ds ☐ ☐

Gallbladder Ds ☐ ☐

Vaginitis ☐ ☐

Diabetes ☐ ☐

Migraine HA ☐ ☐

Epilepsy ☐ ☐

Previous Therapies

Breast Surgery ☐ ☐

GYN Surgery ☐ ☐

Hysterectomy ☐ ☐

Tubal Ligation ☐ ☐

OB Surgery ☐ ☐

Personal History

Caffeine Use ☐ ☐

Tobacco Use ☐ ☐

Alcohol Use ☐ ☐

Herbals ☐ ☐

Reg. Exercise ☐ ☐

Birth Control? ☐ ☐

Family History

Breast Ca ☐ ☐

Ovarian Ca ☐ ☐

Uterine Ca ☐ ☐

Review of Systems

☐ Pain During Urination (Dysuria)

☐ Pain During Intercourse

Entity details for current selection

Prefix Modifier Result Status Episode Onset Duration Value Unit

Figure 40–35: Details

- Browse:** This option enables you to display the Browse pane in the workspace. This pane populates one-third of the form. The Browse pane displays the child term of a selected parent term. On the form, parent terms cause the cursor to change to a question mark. Perform a right mouse click to view the child terms in the Browse pane. Click **Browse** to remove the Browse pane after you have selected the appropriate terms.

0202-45-5743 47yo F Col DOB:07 Jul 1957

AIM - Well Woman Exam AutoNeg Undo Details Browse Shift Browse Note View

History Physical Exam Help Outline View

Chief Complaint / Purpose of Visit

☐ Women's Health Visit

☐ Reason for Visit is Deployment Related

History of Present Illness

Age at Menarche: (years old)

Age at Menopause:

Date of Last Menstrual Period: Onset

Menstrual Bleeding Lasts: (days)

☐ Severe Menstrual Pain

☐ Less Menstrual Bleeding

☐ Excessive Menstrual Bleeding

☐ Bleeding Between Periods

☐ Vaginal Discharge

Additional History of Present Illness:

Past Medical/Surgical History (Continued)

Risk Factors? ☐ ☐

Exposure Hx ☐ ☐

DES Exposure ☐ ☐

STD Exposure ☐ ☐

Trauma Hx ☐ ☐

Surgical Hx ☐ ☐

Pregnancy Hx ☐ ☐

Dietary Hx ☐ ☐

Additional Past Medical/Surgical History:

Previous Diagnoses

Hypertension ☐ ☐

Thrombus ☐ ☐

Liver Ds ☐ ☐

Gallbladder Ds ☐ ☐

Vaginitis ☐ ☐

Diabetes ☐ ☐

Migraine HA ☐ ☐

Epilepsy ☐ ☐

Previous Therapies

Breast Surgery ☐ ☐

GYN Surgery ☐ ☐

Hysterectomy ☐ ☐

Tubal Ligation ☐ ☐

OB Surgery ☐ ☐

Personal History

Caffeine Use ☐ ☐

Tobacco Use ☐ ☐

Alcohol Use ☐ ☐

Herbals ☐ ☐

Reg. Exercise ☐ ☐

Birth Control? ☐ ☐

Family History

Breast Ca ☐ ☐

Ovarian Ca ☐ ☐

Uterine Ca ☐ ☐

Review of Systems

☐ Pain During Urination (Dysuria)

☐ Pain During Intercourse

Entity details for current selection

Prefix Modifier Result Status Episode Onset Duration Value Unit

Sx Hx Px Tx Dx Rx

Close Trees Shift Trees

☒ Bleeding Between Periods

☐ light (spotting)

☐ heavy (menorrhagia)

Figure 40–36: Browse

- **Shift Browse:** Use this option to shift where the Browse pane appears. If it currently populates the right-third of the form, clicking this button moves the pane to the left-third. You can use this option if you want to keep the Browse pane always available as you move through the columns in a form.
- **Note View:** This option enables you to navigate from the Forms tool to the traditional S/O layout, where you can see how your documentation is progressing based on what you have selected in the form. Click **Form View** on the Toolbar to return to the form view.

Figure 40-37: Note View

40.4.2.2 MEDCIN Forms Tabs

All of the forms included with the system use tabs to enable navigation from section to section: History, Physical Exam, Help, and Outline view.

Click the tabs to navigate to different sections within the form.

Figure 40–38: Physical Exam Tab

40.4.2.3 MEDCIN Forms Workspace

The workspace uses three columns, with findings and terms and related options included in each column. This is the basic view of a form, and the form is fully displayed.

The second view of a form is the Details view. You access this view by selecting a term of finding in the form, then clicking Details in the toolbar. In the Details view, you can add more detailed information to the term you selected, including a prefix, modifier, onset date, or status.

40.4.3 Documenting S/O with a Form

Because of the number and diversity of the forms provided with the system, there are different ways you can use each form to document the S/O for an encounter. In this section we cover some of the basics of using a form.

40.4.3.1 Adding Terms

You should always view each finding as a statement that is either True or False. On the History tab, the statements always describe an abnormal condition; the patient has severe menstrual bleeding. On the History tab, True responses always imply a clinical abnormality.

On the PE tab, the statement always describes a clinically normal condition (i.e., the heart is of regular rate and rhythm, the abdomen is soft without masses). True responses always imply a clinically normal condition on the PE tab.

Tip:
On the History tab,
True = abnormal. On
the PE tab, True =
normal.

Figure 40–39: MEDCIN Form

40.4.3.2 Changing the Stats of a Term

If you accidentally clicked the wrong box (clicked the true box instead of false), you can simply click the opposite box to change the response.

40.4.3.3 Removing a Term

If you want to deselect a term and remove it from the note entirely, simply deselect the box that is currently marked. A warning window appears, asking if you want to remove the term. Click **OK** to remove the term, or **Cancel** to keep it.

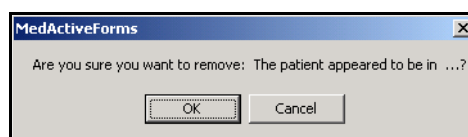


Figure 40–40: MedActiveForms Window

40.4.3.4 Using the Free Text Icon

Click the free text icon next to a term to add more details to that term. A free text window opens, allowing you to add text. After you enter your free text, click **Close The Note Dialog** to close the window and add your free text. Notice that the icon changes once free text is added to a term.

Note: There is a 2,000 character restriction for each free text area.

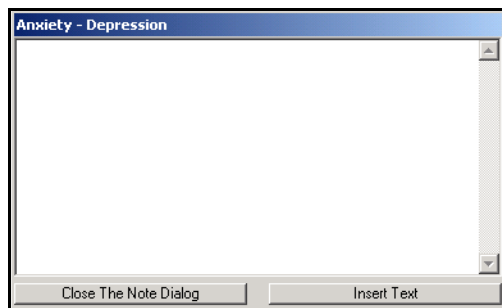


Figure 40-41: Free Text Field

40.4.3.5 Using the Free Text Fields

There are multiple free text fields located throughout the forms. Use these fields to add additional information that pertains to the specific section of the note. Click in the free text field and enter your note. Double-clicking in the free text field opens the free text field in a separate window where text can be added, using either the virtual keyboard or your regular keyboard. Virtual keyboard letters are added by clicking them with your mouse.

Note: There is a 2,000 character restriction for each free text area.

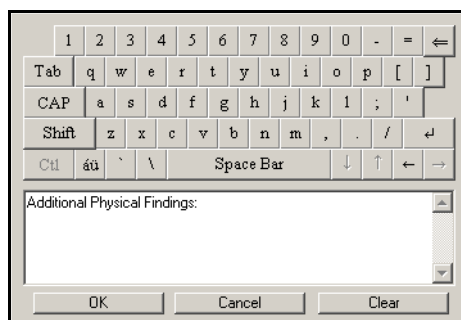


Figure 40-42: Free Text Field Window

40.4.3.6 Using Numeric/Date Entry

Some of the answers to the questions on the forms will be numbers or dates. In these cases, either click in the field and enter the value or double-click in the field to open the Numeric/Date Entry window. The Numeric/Date Entry window displays either the Interval view tab or Calendar view tab, depending on the field. Click the value(s), then click **OK**.

1	2	3	4	5	
6	7	8	9	0	
Yr	Mon	Wk	Day	Hr	Min

Bksp Erase

Interval view Calendar view

OK Cancel

Figure 40-43: Interval View Tab

September 2004

Sun	Mon	Tue	Wed	Thu	Fri	Sat
23	30	31	1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	1	2
3	4	5	6	7	8	9

Precision of calendar date
☒ Day ☐ Month ☐ Year

Interval view Calendar view

OK Cancel

Figure 40-44: Calendar View Tab

40.4.3.7 Using AutoNeg

The “Neg” in AutoNeg is “clinically negative,” which means clinically normal. Use AutoNeg to document all undocumented findings as clinically normal. Use this feature by manually selecting your true findings, then click **AutoNeg** to document the remaining terms. This is called documentation by exception.

AutoNeg also is a dual-purpose option that enables you to automatically select all positive or all negative values for a displayed form page. In order use this option, simply click the **arrow** to the right of the option, then select either **AutoPos** or **AutoNeg**. Selecting one of the options populates the form with the type of value you chose.

The screenshot displays the MEDCIN Form interface for a patient named 0202-45-5743, 47yo F, Col, DOB: 07 Jul 1957. The interface includes a toolbar at the top with buttons like Save, Save As, Template Mgt, Dx Prompt, End Term, Browse From Here, A/P, Disposition, Sign, Cancel, and Close. Below the toolbar, there are tabs for History, Physical Exam, Help, and Outline View. The main area is divided into several sections, each with a list of findings and checkboxes for selection. The sections include:

- General Appearance:** Current Vital Signs Reviewed, Alert, Well Developed, Well Nourished, No Acute Distress.
- Examination of the Neck:** Thyroid Not Diffusely Enlarged.
- Examination of the Lymph Nodes:** Cervical Lymph Nodes Not Enlarged, Lymph Nodes of Normal Consistency.
- Examination of the Breasts:** Breasts Without Palpable Mass.
- Examination of the Abdomen:** Abdomen Normal to Visual Inspection, Bowel Sounds Normal, Abdomen Soft, No Abdominal Muscle Guarding, No Abdominal Rigidity, No Direct Abdominal Tenderness, No Abdominal Rebound Tenderness, No Abdominal Mass.
- Liver and Spleen:** Liver Normal to Palpation, Spleen Normal to Palpation.
- Examination of the Female Genitalia:** External Genitalia Without Abnormalities, Normal Vaginal Mucosa, Without Vaginal Discharge, Without Vaginal Vesicle(s), Without Vaginal Tenderness, Without Vaginal Cystocele, Without Vaginal Rectocele.
- Female Pelvic Examination:** No Cervical Discharge, No Cervical Lesion, No Cervical Pain Elicited By Motion, Pap Smear NOT Done, Uterus Position Normal, Without Uterine Enlargement, Uterus Not Surgically Absent, Uterus Non-tender, Adnexae Non-tender, Adnexae Not Surgically Absent, Without Ovarian Mass.
- Examination of the Rectum:** Anal Sphincter Tone Normal, No Hemorrhoids Noted, Without Rectal Mass.
- Test Results:** Negative for Fecal Occult Blood, Normal Vaginal Wet Mount Smear, Negative Vaginal KOH Prep.

Figure 40-45: MEDCIN Form

40.4.3.8 Flipping Terms between the HPI and ROS Headings

In the HPI section, you have the option to flip an HPI finding to ROS. Click the **HPI** button provided next to each term. The term is flipped into the ROS. The ROS section includes similar buttons, but these enable you to flip a term found in the ROS to the HPI. Click the **ROS** button to flip the ROS terms into the HPI.

This close-up shows a list of terms with checkboxes and buttons for flipping between HPI and ROS. The terms are:

- Severe Menstrual Pain
- Less Menstrual Bleeding
- Excessive Menstrual Bleeding
- Bleeding Between Periods
- Vaginal Discharge

Each term has a checkbox and a button labeled 'HPI' or 'ROS'.

Figure 40-46: ROS/HIP Flip

40.4.3.9 Adding Details to an Individual Term

The Details section is hidden on the Forms workspace until you want to view it. To access the Details section, click **Details** on the Toolbar. The Details pane appears at the bottom of the workspace. When the Details section is visible, any time you click on an item in the Form, details about that item appear in the details section. In the details view, you can add more detailed information to the term you selected, including a prefix, a modifier, an onset date or a status. You can also see how the finding is worded in the encounter note.

0202-45-5743 47yo F Col DOB:07 Jul 1957

History Physical Exam Help Outline View

Chief Complaint / Purpose of Visit

☐ Women's Health Visit
☐ Reason for Visit is Deployment Related

History of Present Illness

Age at Menarche: (years old)
 Age at Menopause:
 Date of Last Menstrual Period: Onset
 Menstrual Bleeding Lasts: (days)
☐ Severe Menstrual Pain
☐ Less Menstrual Bleeding
☒ Excessive Menstrual Bleeding
☐ Bleeding Between Periods
☐ Vaginal Discharge
 Additional History of Present Illness:

Past Medical/Surgical History

Prior Tests ☐ ☐

Past Medical/Surgical History (Continued)

Risk Factors? ☐ ☐
 Exposure Hx ☐ ☐
 DES Exposure ☐ ☐
 STD Exposure ☐ ☐
 Trauma Hx ☐ ☐
 Surgical Hx ☐ ☐
 Pregnancy Hx ☐ ☐
 Dietary Hx ☐ ☐
 Additional Past Medical/Surgical History:

Previous Diagnoses

Hypertension ☐ ☐
 Thrombus ☐ ☐
 Liver Dz ☐ ☐
 Gallbladder Dz ☐ ☐
 Vaginitis ☐ ☐
 Diabetes ☐ ☐
 Migraine HA ☐ ☐
 Epilepsy ☐ ☐

Previous Therapies

Breast Surgery ☐ ☐
 GYN Surgery ☐ ☐
 Hysterectomy ☐ ☐
 Tubal Ligation ☐ ☐
 OB Surgery ☐ ☐

Personal History

Caffeine Use ☐ ☐
 Tobacco Use ☐ ☐
 Alcohol Use ☐ ☐
 Herbs ☐ ☐
 Reg. Exercise ☐ ☐
 Birth Control? ☐ ☐

Family History

Breast Ca ☐ ☐
 Ovarian Ca ☐ ☐
 Uterine Ca ☐ ☐

Review of Systems

☐ Pain During Urination (Dysuria)
☐ Pain During Intercourse

Entry details for current selection:

☐ Menorrhagia

Prefix Modifier Result Status Episode Onset Duration Value Unit

Figure 40-47: Details

40.4.3.10 Browsing the MEDCIN Hierarchy

MEDCIN is organized as an hierarchical tree of clinical findings. A high level finding, such as the abdominal exam (Parent), has subordinate or children findings, such as inspection, auscultation, percussion and so forth. Children findings may have their own children as well. MEDCIN has many levels in this parent/child hierarchy. When you add terms to the S/O, you must pay careful attention because MEDCIN allows a negative response on a parent term, while allowing a positive response on a child term. This would be clinically incorrect.

A form includes many of these parent terms. These terms have children in the MEDCIN hierarchy, but the child terms are not present on the form. Roll your cursor over an item on the form to determine whether that item has associated children. If the item has children, the cursor will change to a cursor-question mark.

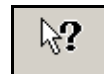


Figure 40-48: Cursor-Question Mark

Right-click the term to display the children. A Browse pane displays, either on the right-third or left-third of the form, showing the additional terms. Select either the large plus (+) or large minus (-) sign next to the terms you want. You can close the Browse pane by clicking **Close Trees** on the Browse pane or by clicking **Browse** on the Toolbar. You can shift the Browse pane to the left-third or right-third of the form by clicking **Shift Trees** on the Browse pane, or by clicking **Shift Browse** on the Toolbar.

Save SaveAs Template Mgt Dx Prompt EndTerm Browse From Here A/P Disposition Sign Cancel Close

1/202-45-5743 47yo F Col DOB:07 Jul 1957

V NKA Options

<< >> AIM - Well Woman Exam AutoNeg Undo Details Browse Shift Browse Note View

History Physical Exam Help Outline View

Chief Complaint / Purpose of Visit

☐ Women's Health Visit
☐ Reason for Visit is Deployment Related

History of Present Illness

Age at Menarche: (years old)
Age at Menopause:
Date of Last Menstrual Period: Onset
Menstrual Bleeding Lasts: (days)
☐ Severe Menstrual Pain
☐ Less Menstrual Bleeding
☒ Excessive Menstrual Bleeding
☐ Bleeding Between Periods
☐ Vaginal Discharge
Additional History of Present Illness:

Past Medical/Surgical History

Prior Tests ☐

Past Medical/Surgical History (Continued)

Risk Factors? ☐ ☐
Exposure Hx ☐ ☐
DES Exposure ☐ ☐
STD Exposure ☐ ☐
Trauma Hx ☐ ☐
Surgical Hx ☐ ☐
Pregnancy Hx ☐ ☐
Dietary Hx ☐ ☐
Additional Past Medical/Surgical History:

Previous Diagnoses

Hypertension ☐ ☐
Thrombus ☐ ☐
Liver Ds ☐ ☐
Gallbladder Ds ☐ ☐
Vaginitis ☐ ☐
Diabetes ☐ ☐
Migraine HA ☐ ☐
Epilepsy ☐ ☐

Sx Hx Px Tx Dx Rx

Close Trees Shift Trees

☒ Bleeding Between Periods
☐ light (spotting)
☐ heavy (menorrhagia)

Entry details for current selection

☐ Bleeding between periods

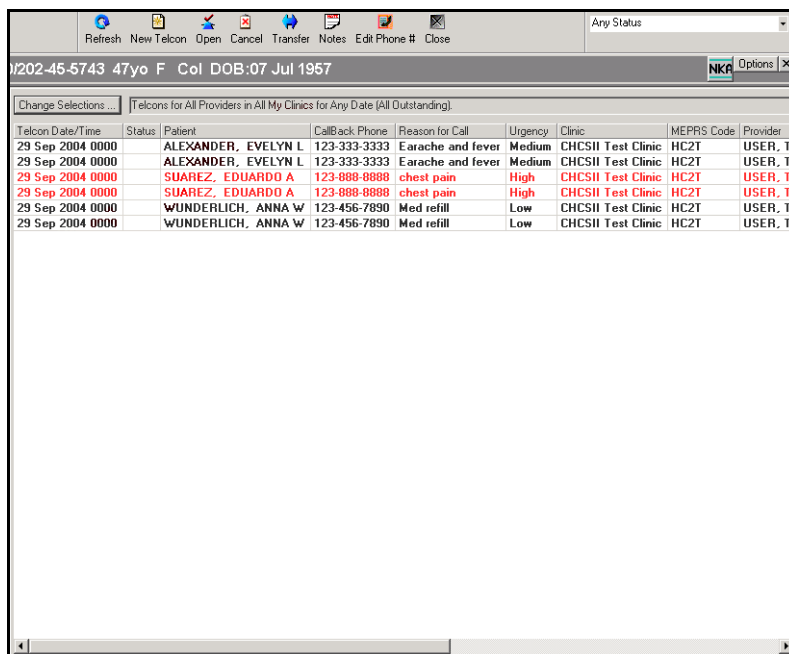
Prefix	Modifier	Result	Status	Episode	Onset	Duration	Value	Unit
				...				

Figure 40–49: Browse Pane

41.0 TELEPHONE CONSULTS

41.1 Telephone Consults Overview

The Telephone Consults module enables telephone calls to be recorded and tracked. The Telephone Consult (telcons) module displays telephone consults for specified clinics, providers, dates, and statuses. From the Telephone Consults module, telcons can be created, viewed, transferred to another provider, and canceled. Phone numbers can be edited, notes viewed, and an encounter can be opened for that appointment.



Telcon Date/Time	Status	Patient	CallBack Phone	Reason for Call	Urgency	Clinic	MEPRS Code	Provider
29 Sep 2004 0000		ALEXANDER, EVELYN L	123-333-3333	Earache and fever	Medium	CHCSII Test Clinic	HC2T	USER, TI
29 Sep 2004 0000		ALEXANDER, EVELYN L	123-333-3333	Earache and fever	Medium	CHCSII Test Clinic	HC2T	USER, TI
29 Sep 2004 0000		SUAREZ, EDUARDO A	123-888-8888	chest pain	High	CHCSII Test Clinic	HC2T	USER, TI
29 Sep 2004 0000		SUAREZ, EDUARDO A	123-888-8888	chest pain	High	CHCSII Test Clinic	HC2T	USER, TI
29 Sep 2004 0000		WUNDERLICH, ANNA W	123-456-7890	Med refill	Low	CHCSII Test Clinic	HC2T	USER, TI
29 Sep 2004 0000		WUNDERLICH, ANNA W	123-456-7890	Med refill	Low	CHCSII Test Clinic	HC2T	USER, TI

Figure 41–1: Military Clinical Desktop—Telephone Consults Module

41.1.1 In More Depth

The Telephone Consults module enables telephone calls to be recorded and tracked. The Telephone Consult (telcons) module displays telephone consults for specified clinics, providers, dates, and statuses. From the Telephone Consults module, telcons can be created, viewed, transferred to another provider, and cancelled. Phone numbers can be edited, notes viewed, and an SF600 can be created for that appointment.

Similar to the Appointments function telcons can be filtered for the following:

- **Set as Default:** Customized default settings from the Telephone Consult Search Selections dialog box.
- **All Outstanding:** Telephone consults with the status 'outstanding.'
- **Today Only:** Today's telephone consults.

- **Today Plus Incomplete:** Today's telephone consults that have a status of incomplete.
- **Any Status:** Telephone consults that meet any status and meet the date criteria set in the Telephone Consult Log Selections window.
- **Pending:** Telephone Consults that have a status of pending and meet the date criteria set in the Telephone Consult Log Selections dialog box. No note has been initiated.
- **InProgress:** Telephone Consults that have a status of In Progress and meet the date criteria set in the Telephone Consult Log Selections window. The note has been initiated.
- **Complete:** Telephone consults that have a status of complete and meet the date criteria set in the Telephone Consult Log Selections dialog box. The encounter document has been signed.
- **Updated:** Telephone consults that have a status of updated and meet the date criteria set in the Telephone Consult Log Selections window. The encounter document has been completed and then amended. Use this function to filter the telephone consult list for the current session. Use the Change Selections function to select a filter to use as the default. To filter the list of telephone consults, select a filter from the drop-down list in the top, right corner on the Telephone Consults module.
- **Transfer:** The Telcon Transfer option enables an individual telcon or a group of telcons to be transferred to a different provider within the same clinic.
- **Notes:** Allows notes associated with the telephone consult to be viewed.
- **Edit Phone #:** Allows the call back number to be changed. The system defaults to the home number.
- **Close:** Closes the Telephone Consult module.

Note: If the column headings have been re-ordered on the Telephone Consults module, click **Set Column Order as Defaults** to keep this heading order each time the Telephone Consults module is opened. Click **Restore Column Order Defaults** to return the column heading order to the system default.

41.2 Setting the Properties of the Telephone Consults Module

Follow the steps below to set the properties of the Telephone Consults module:

1. On the Telephone Consults module, click **Change Selections**. The Telephone Consult Search Selections window opens.

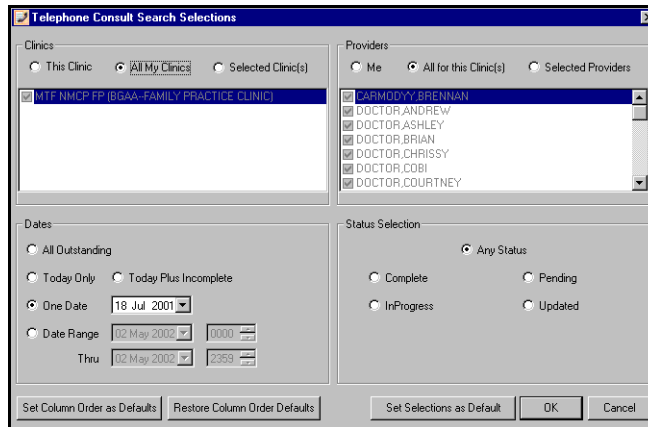


Figure 41–2: Telephone Consult Search Selections Window

2. Select the applicable option in the Clinics area.
 - **This Clinic:** Telephone consults for this clinic only.
 - **All My Clinics:** Telephone consults for all of the provider’s clinics.
 - **Selected Clinic(s):** Only telephone consults for the selected clinics.
3. Select the applicable option in the Providers area.
 - **Me:** Telephone consults for the current provider only.
 - **All for this Clinic(s):** All telephone consults for the current clinic(s).
 - **Selected Providers:** Only telephone consults for the selected providers.
4. Select the applicable option in the Dates area.
 - **All Outstanding:** Telephone consults with the status of outstanding.
 - **Today Only:** Only today's telephone consults.
 - **Today Plus Incomplete:** Today's telephone consults that have a status of incomplete.
 - **One Date:** Only telephone consults for a selected date.
 - **Date Range:** All telephone consults that fall within a specified date range.
5. Select the applicable option in the Status Selection area.
 - **Any Status:** Telephone consults that meet any status and meet the date criteria set in the Telephone Consult Log Selections window.
 - **Pending:** Telephone Consults that have a status of pending and meet the date criteria set in the Telephone Consult Log Selections window. No note has been initiated.
 - **InProgress:** Telephone Consults that have a status of In Progress and meet the date criteria set in the Telephone Consult Log Selections window. The note has been initiated.

- **Complete:** Telephone consults that have a status of complete and meet the date criteria set in the Telephone Consult Log Selections window. The encounter document has been signed.
 - **Updated:** Telephone consults that have a status of updated and meet the date criteria set in the Telephone Consult Log Selections window. The encounter document has been completed and then amended.
6. Click **Set Selections as Default** or click **OK** to set the selected search criteria as the default criteria. The telephone consults that meet the required criteria displays.

Note: If the column headings have been re-ordered on the Telephone Consults module, click **Set Column Order as Defaults** to keep this heading order each time the Telephone Consults module is opened. Click **Restore Column Order Defaults** to return the column heading order to the system default.

41.3 Canceling a Telephone Consult

Follow the steps below to cancel a telephone consult:

1. Select the telephone consult to be canceled.
2. On the Action bar, click **Cancel**. The Cancel Telcon window opens.

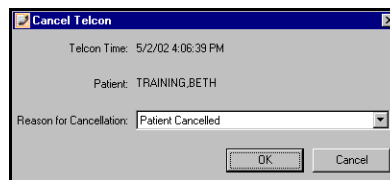


Figure 41–3: Cancel Telcon Window

3. Select a reason for the cancellation from the drop-down list.
4. Click **OK**.

41.4 Editing the Callback Phone Number

Follow the steps below to edit the callback phone number:

1. Select the telephone consult to be modified.
2. On the Action bar, click **Edit Phone #**. The Change Callback Number window opens.

Tip:

This does not change the patient's home phone number in the Demographics module.

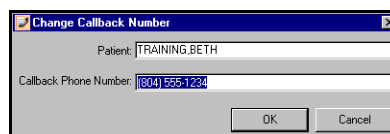


Figure 41–4: Change Callback Number Window

3. In the **Callback Phone Number** field, enter the new phone number.
4. Click **OK**.

41.5 Opening an Encounter

Follow the steps below to open an encounter:

1. Select the telephone consult on the Telephone Consult module.
2. On the Action bar, click **Open**. The Telcon Quick Entry window opens.
3. Click **Cancel**. The Telcon Quick Entry window closes and the patient encounter is displayed.

41.6 Creating a New Telephone Consult

Follow the steps below to create a new telephone consult:

1. On the Action bar, click **New Telcon**. The New Unscheduled Appointment/Telcon Visit window opens, immediately overlaid by the Patient Search window.
2. Search for the patient you want to schedule a telephone consult for, or if the patient is already loaded, click **Cancel**. The New Unscheduled Appointment/Telcon Visit window displays.

New Unscheduled Appointment/Telcon Visit

BUTT, ALEXANDRA C 01/728-16-5068 07 May 1991
Home Phone:(171)7925380 Work Phone:

Change Patient ...

Date & Time: 13 Aug 2004 1102
Assigned Clinic: MTF NMCP FP[BGAA]
Provider: PROVIDER,JOE

Appointment Type: TELEPHONE CONSULT (T-CON)* 20

Appointment Classification: ☒ Outpatient

Meets Outpt Visit Criteria (Workload)?
☒ Yes ☐ No ?

☐ Related to Injury/Accident? ...

Call Back Number: (171)7925380

Reason for Telephone Consult:

Urgency: ☐ High ☐ Medium ☒ Low

Notes:

OK Cancel

Figure 41-5: New Unscheduled Appointment/Telcon Visit Window

3. Complete the following fields:

- **Assigned Clinic:** Select the assigned clinic from the drop-down list.
- **Provider:** Use the drop-down list to select the desired provider.
- **Appointment Type:** The only Appointment Type choice is **TELEPHONE CONSULT (T-CON*) 20**.

Note: Appointment types with a \$ or * annotate those types of appointments that can only be created by the clinic.

- **Appointment Classification:** This defaults based on the patient's appointment classification.
- **Meets Outpt Visit Criteria (Workload?):** Defaults to Yes, but if the patient does not meet outpatient visit criteria, select No.
- **Related to Injury/Accident:** Select the checkbox to indicate that the telcon is related to an injury/accident.
- **Call Back Number:** Enter the phone number where the patient can be reached. The default number is the patient's home phone.
- **Reason for Telephone Consult:** Enter a short description of the problem for the patient called.
- **Urgency:** Select either **High**, **Medium**, or **Low**.
- **Notes:** Enter any comments pertaining to the telephone consult.

4. Click **OK** to save the appointment.

Note: Click **Change Patient** to search for a new patient. The Patient Search window opens. If you click **Change Patient** before clicking **OK**, the telephone consult for the patient cannot be created.

Note: If you have privileges to view encounter information, the Telcon Quick Entry window opens, allowing for continued documentation.

41.7 Completing the Telcon Quick Entry Screen

Follow the steps below to complete the Telcon Quick Entry screen:

1. Double-click the desired telephone consult from the list. The Telcon Quick Entry window opens.

Figure 41–6: Telcon Quick Entry Window

2. Complete the applicable fields:
 - **Provider Note:** Enter free-text to document the S/O portion of the encounter.
 - **Diagnoses:** The diagnoses can be selected from the Template List, Problem List (Acute or Chronic), or Clinic and User Favorite Lists. You can also search for the diagnosis by entering the diagnosis in the **Search** field and clicking **Find Now**. Select the diagnosis and click **Add** to add the diagnosis to the Selected Diagnosis list.
 - **E&M:** Select an **E&M code** from the drop-down list.
3. Select the desired **Save** option:
 - **Save and Sign:** Saves the information and opens the Sign Encounter window.
 - **Save and Open A/P:** Saves the information, writes it into the Patient Encounter module, and opens the Assessment and Plan module.
 - **Save and Return to Encounter:** Saves the information and returns you to the encounter document.

4. Click **OK**.

Note: Once information has been entered and saved via the Quick Entry Screen, the Quick Entry Screen is not available to document additional data.

41.8 Transferring a Telephone Consult

The Telcon Transfer window enables an individual telcon or a group of telcons to be transferred to a different provider within the same clinic.

Follow the steps below to transfer a telephone consult:

1. Select the telephone consults to be transferred.
2. On the Action bar, click **Transfer**. The Telcon Transfer window opens.

Tip:

If transferring multiple telcons, the patients must be from the same clinic.

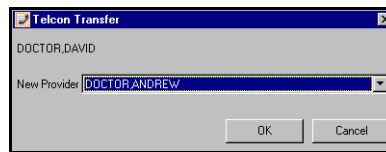


Figure 41–7: Telcon Transfer Window

3. Select a new provider from the New Provider drop-down list. Only providers assigned to the specific clinic are available.
4. Click **OK** to execute the transfer. The telephone consult is added to the new provider's telephone consults list.

41.9 Viewing a Telcon Note

If a comment was added on the New Telcon window, the full text of the comment cannot be seen on the Telephone Consults module.

Follow the steps below to view a telcon note:

1. Select the telephone consult on the Telephone Consult module.
2. On the Action bar, click **Notes**. The Appointment Note window opens containing the comment.

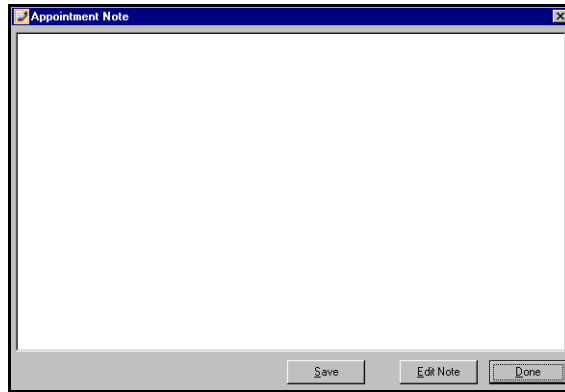


Figure 41–8: Appointment Note Window

3. Click **Done** to close the window and return to the Telephone Consults module.

Note: Click **Edit Note** to edit information in the note. When all edits have been made, click **Save**.

42.0 TEMPLATE MANAGEMENT

42.1 Template Management Overview

Templates are used to streamline the encounter documentation process. Each encounter template contains placeholders for diagnoses, procedures, orders, S/O Notes templates, AutoCited items, and the associated reason for visit. Once an encounter template has been selected and loaded into the encounter, the pre-positioned lists are available within S/O and A/P. The Template Management module is generally accessed while in an encounter after the screening process and before any charting is completed. The Encounter templates can be viewed and edited without an open encounter.

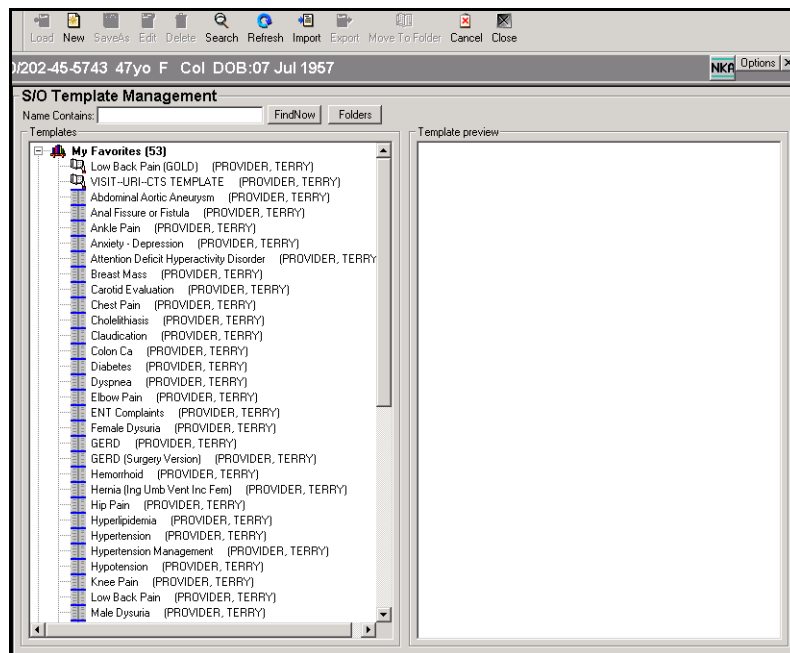


Figure 42-1: Military Clinical Desktop—Template Management Module

42.1.1 In More Depth

The Encounter template contains details of the encounter in terms of AutoCite items, diagnoses, procedures, S/O templates, orders, and patient instructions. The system provides suggested templates based on the reason for visit and the patient problems associated with the current, open encounter. Typically, the provider selects an encounter template from the Patient Encounter module before documenting the exam.

The top portion of the workspace shows the criteria for the suggested templates. The Reason for Visit and Problems are included in the criteria by default. The suggested templates are listed in the Autosearch Results folder. Templates denoted as favorites or in the clinic list are displayed in the applicable folder.

Templates can be added to the Favorites List to be seen as suggested templates for every encounter. A template search can also be conducted with only the Favorites List. Templates can be added to or removed from the Favorites List from either the Template Selections or Search/Browse tab.

A template can be imported to or exported from another location. All of the details of the template are included when it is imported or exported. Since the template contains all details, the order sets included are specific to the originating clinic. If the template is imported/exported to another clinic or host location, the orders are deleted upon import. You can import/export a template from the Template Selections or Search/Browse tab.

After an encounter has been documented, the structure can be saved as an encounter template. No patient-specific information is saved. This action can be performed from the Current Encounter and Previous Encounter modules.

42.2 Organizing Templates

The Template Selections tab allows you to organize templates in the Template Management module. The Template Selections tab lets you add, edit and delete folders to manage encounter templates.

Note: You must have a current encounter open to access the Template Selections tab.

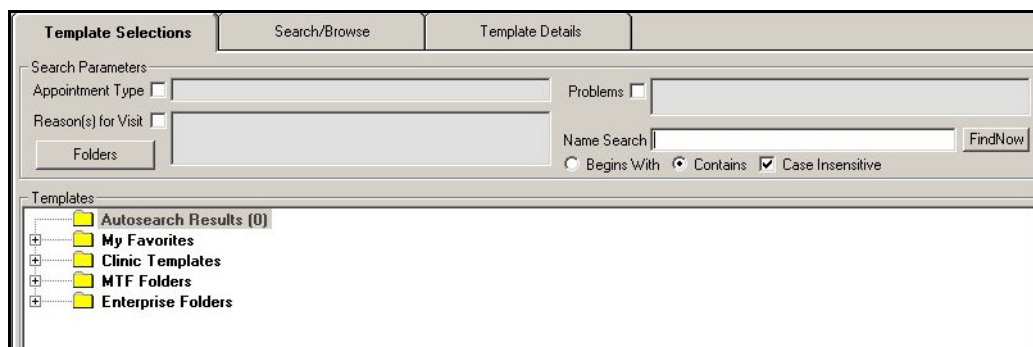


Figure 42–2: Template Folders

Follow the steps below to organize encounter templates:

1. In the Template Management module, Template Selections tab, click **Folders** to open the Template Folder Management window.

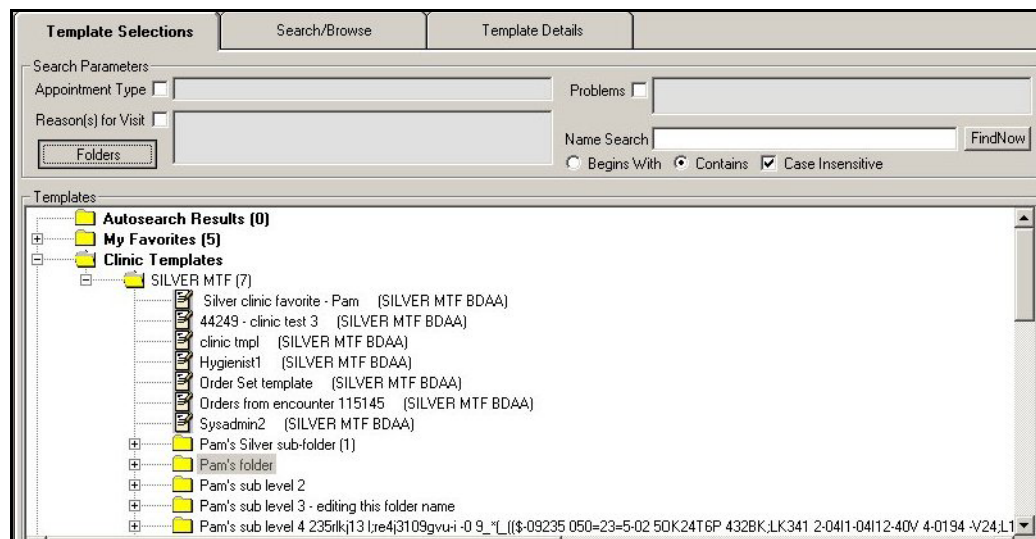


Figure 42-3: Clinic Templates Sub Folders

2. Click **New** to create a new folder for encounter templates.

Note: If there is a folder you want to modify, click **Edit**. If there is a folder you want to delete, click **Delete**.

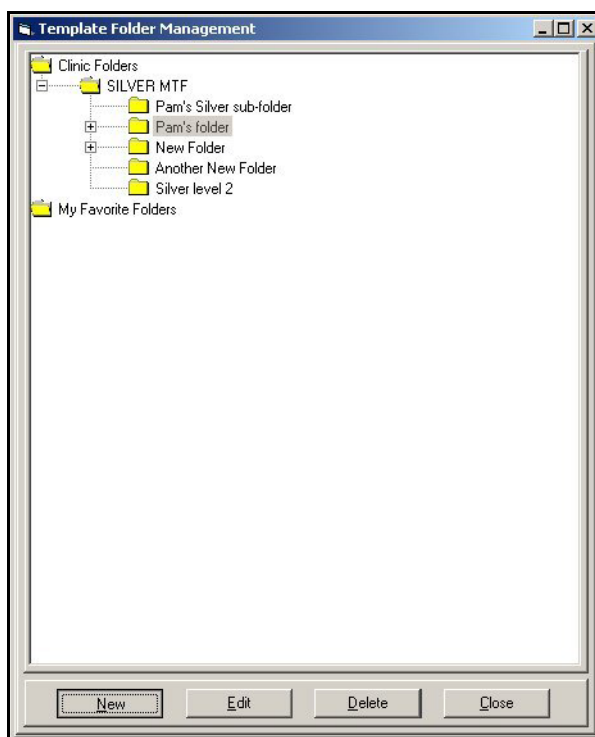


Figure 42-4: Template Folder Management Window

3. In the New Folder window, enter the name of the folder you are using to organize your templates.
4. Click **OK** to add the folder to the Template Management module. You are returned to the Template Folder Management window.

Note: In the Template Folder Management window, select the top-level folder and click **New** to add a sub-folder. Enter the name of the sub-level folder and click **OK**.

5. Repeat steps 3 and 4 for each template management folder you want to add. When you are finished adding the folders, click **Close** to return to the Template Management module Template Selections tab.

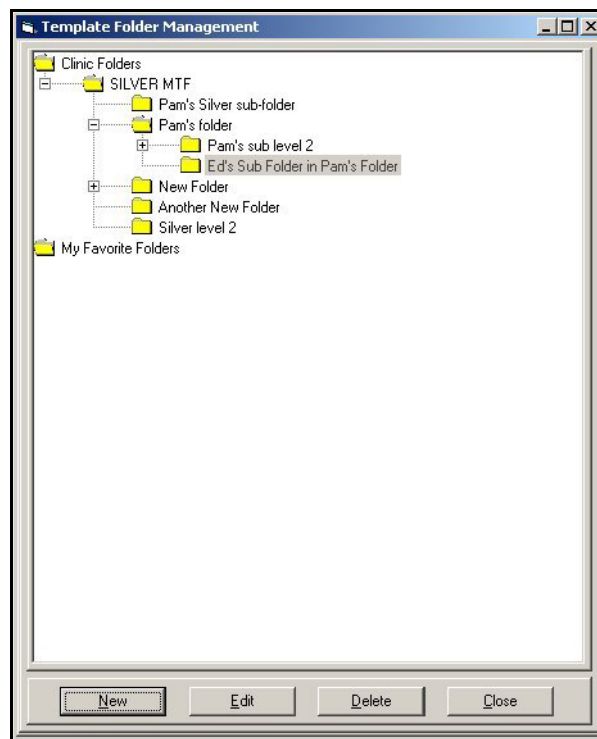


Figure 42-5: Template Folder Management Window—Complete

42.3 Moving Templates to Folders

The Template Management module lets you easily move templates from one folder to another. This enables templates to be categorized into proper folders allowing you to access and use templates more efficiently.

Note: Moving templates from one folder to another does not create a copy of the template. Therefore, it is not recommended that you move templates out of shared folders into personal folders without commanding officer consent.

Follow the steps below to move templates to a specific folder:

1. In the Template Management module, select the template you want to move.
2. Perform a right mouse click and select **Move to Folder**.
3. In the Template Folder Management module, select the folder where you want to move the template.
4. Click **Move**. The template is moved from the original (folder) location to the new location.

42.4 Selecting an Encounter Template

An Encounter Template can be selected and loaded into an encounter. The Encounter template contains details of the encounter in terms of AutoCite items, diagnoses, procedures, S/O templates, orders, and patient instructions. The system provides suggested templates based on the reason for visit and the patient problems associated with the current, open encounter. Typically, the provider selects an encounter template from the Patient Encounter module before documenting the exam.

Follow the steps below to select an encounter template from the Patient Encounter module:

1. Click **Templates** on the Action bar. The Template Management module opens with the Template Selections tab defaulted.

Note: The top portion of the workspace shows the criteria for the suggested templates. The Reason for Visit and Problems are included in the criteria by default. Click the checkboxes to remove them. If changes are made to the criteria, the system displays an updated list.

Note: The Template Selection tab auto-refreshes when a template is imported, displaying the imported template in the template list.

Note: The suggested templates are listed in the Autosearch Results folder. Templates denoted as favorites or in the clinic list are displayed in the applicable folder.

Tip:

*If the desired template is not listed in any of the folders a search can be conducted. In the top portion of the workspace type in the name of the template in the Name Search field. Click **Find Now** to view the results in the Name Search Results folder.*

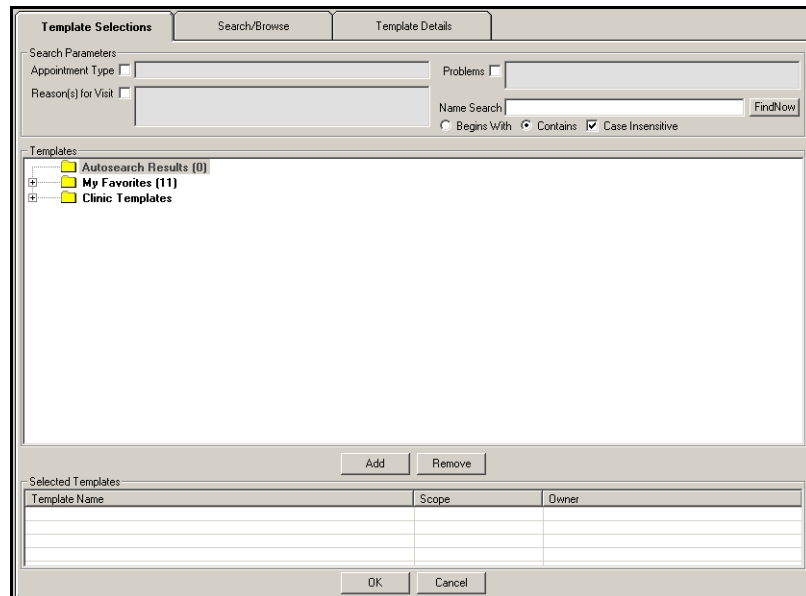


Figure 42-6: Template Management Module—Template Selections Tab

2. Select the **Folders** button to add, edit or delete a folder. The Template Folder Management window opens.
 - In the Template Folder Management window, click **New**. The New Folder window opens.
 - In the New Folder window, enter the name of the new folder and click **OK**. The new folder is added to the Template Folder Management window.
 - Highlight the folder and click **New** to add a sub-folder. The New Folder window opens.
 - Enter the name of the sub-folder and click **OK**. The sub-folder is added in the Template Folder Management window.
 - Add additional sub-folders in the same manner. When finished, click **Close**. The new folders and sub-folders are added to the Template Selections tab of the Templates Management module.
3. Select the template to be used in the encounter from one of the folders or through a template search.
4. Click **Add** to move the template into the Selected Templates area. More than one template can be added to an encounter.
5. Click **OK** to load the template(s) into the encounter. The Patient Encounter module opens with the embedded template(s).

Note: The template details are displayed within the Patient Encounter (AutoCite), S/O (notes template), and A/P (diagnoses, procedures, orders, and patient instructions) modules.

Follow the steps below to set an Encounter Template as a default that automatically loads for each subsequent new encounter:

1. Highlight the desired template in the Encounter Template list.
2. Right-click on the highlighted template and select **Default Encounter Template** from the right-click pop-up menu.

42.5 Setting an Encounter Template as a Default

Any encounter template may be designated to load for every encounter. This eliminates the need to open the Template Management module to load a template. Typically, the most common diagnoses, procedures, and orders are included in this default encounter template. Once an encounter template is designated as the default template, it can be reset so that no encounter template is automatically loaded.

Follow the steps below to set an Encounter Template as a default:

1. On the Search/Browse tab or the Template Selections tab, highlight the desired template in the Encounter Template list.
2. Right click on the highlighted template and select **Default Encounter Template** from the right-click pop-up menu.

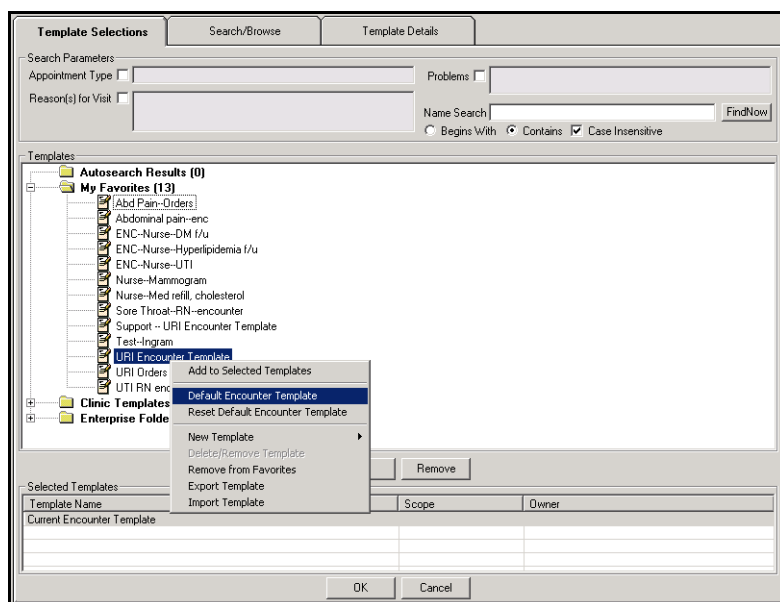


Figure 42-7: Setting the Default Encounter Template

3. The highlighted template is now followed with the indication of Default Encounter Template.

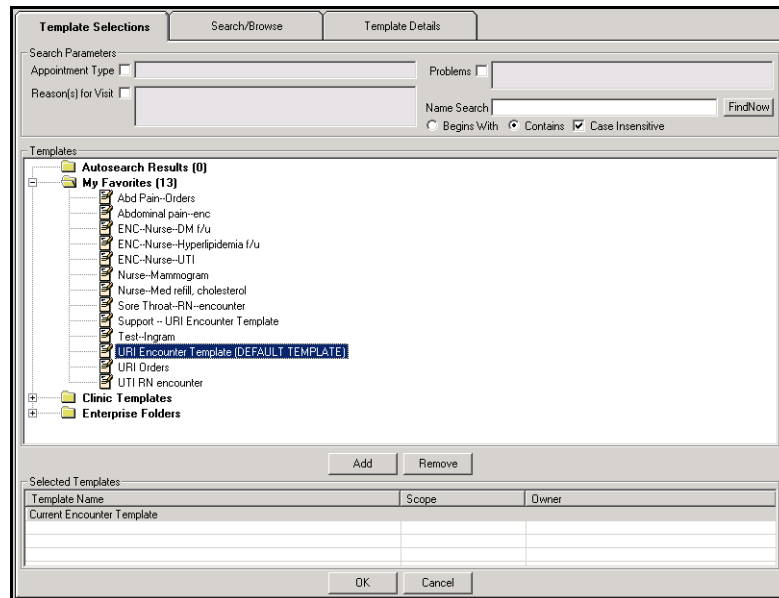


Figure 42–8: Default Encounter Template Set

Follow the steps below to reset the default encounter template:

1. On the Search/Browse tab or the Template Selections tab, highlight the current default encounter template.
2. Right click on the highlighted template and select **Reset Default Encounter Template**.
3. The default template designation is removed from the template.

42.6 Creating a New Template

Follow the steps below to create a new template, begin on the Template Selections or Search/Browse tabs.

1. Click **New** on the Action bar. The Template Details tab displays.

Figure 42-9: Template Management Module—Template Details Tab

2. Complete the following fields on the Template Details tab:
 - **Owner Type:** Select the desired owner type from the drop-down list. Options include Personal, Clinic, MTF, or Enterprise. The user's role determines whether the template can be saved as clinic, MTF, or enterprise.
 - **Specialty:** Select the specialty to which the template belongs from the drop-down list. This is a required field.
 - **E&M Code Category:** Select the desired codes for the template from the drop-down list.

Note: The template name is added upon saving and the **User** field is read-only. Templates can only be shared between providers in the same clinic.

3. Click **Add** to add details to the template in the following areas, where applicable:
 - **Associated Reasons for Visit:** In the **Search Term** field, enter the first few letters of the complaint and click **Search**. Select the complaint from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
 - **Associated Problems:** In the **Search Term** field, enter the first few letters of the problem and click **Search**. Select the problem from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
 - **Diagnoses:** In the **Search Term** field, enter the first few letters of the diagnosis and click **Search**. Select the diagnosis from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
 - **Notes Templates:** Click **Search** to open the List Note Template Search window. Enter search criteria in the window and click **Search**. Select the note

Tip:
The Associated Reasons for Visit, the Associated Problems, Associated Appointment Types and Items to Autocite into Note areas lend limited support in the creation and use of an encounter template.

template and click **Add Items**. Click **Done** to return to the Template Details tab.

- **Other Therapies:** In the **Search Term** field, enter the first few letters of the therapy and click **Search**. Select the therapy from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
- **Associated Appointment Types:** In the **Search Term** field, enter the first few letters of the appointment type and click **Search**. Select the appointment type from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
- **Items to AutoCite into Note:** Select an AutoCite selection from the list and click **Add Items**. Click **Done** to return to the Template Details tab.
- **Procedures:** In the **Search Term** field, enter the first few letters of the procedure and click **Search**. Select the procedure from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.

4. Click **Save As**. The Save Encounter Template window opens.

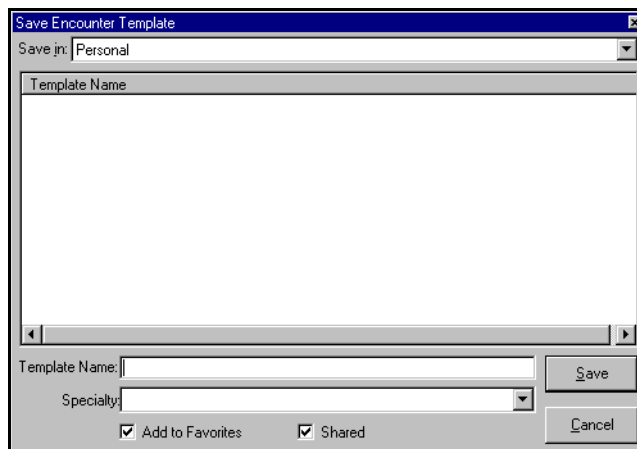


Figure 42–10: Save Encounter Template Window

5. Select a **template type** from the Save in drop-down list.
6. In the **Template Name** field, enter the template name.
7. Select a **Specialty** from the drop-down list.

Note: Click **Add to Favorites** if you want the template to be added to the Favorites List to be shared with other Clinical Team members.

8. Click **Save**.

42.7 Searching for a Template

In order to do any work with a template, you must select a template with the Template Selections or Search/Browse tabs.

Follow the steps below to search for a template:

1. Click **Search**. The Encounter Template Search window opens.

Figure 42–11: Encounter Template Search Window

2. Complete the following search criteria fields, as necessary:
 - **Template Name:** Enter the name or the first word of the template. Select the applicable radio button to denote if the template name begins with or contains entered text. The search is case-insensitive by default. Deselect the checkbox to make the search case-sensitive.
 - **Select from My Favorites Only:** Select the checkbox to search Favorite templates only.
 - **Owner Type:** Use the drop-down list to select the desired type. Options include:
 - Personal
 - Clinic, MTF
 - Enterprise
 - **Owners:** Click **Add** to open the Template Owner Lookup window and select another provider. This enables you to search another provider's templates.
 - **Specialty:** Select the specialty to which the template belongs from the drop-down list.
 - **Associated Reason for Visit:** Click **Add** to add a reason for visit by which to search.
 - **Associated Appointment Type:** Click **Add** to add an appointment type by which to search.
 - **Associated Problem:** Click **Add** to add problems by which to search.

- **Replace Search Results or Add to Search Results:** Click a radio button to either show results from the current search (Replace) or add the current results to the list of templates (Add).
3. Click **Search** to view the templates that match the criteria. The templates are displayed on the Search/Browse tab.

Note: Once a template has been found and selected, the following actions can be taken:

- View and edit the template
 - Merge templates (more than one template must be selected)
 - Copy a template
 - Remove or add to the Favorites List
 - Export a template
 - Delete a template
 - Select an Encounter template
-

42.8 Editing a Template

Follow the steps below to edit a template:

1. Search for the template you want to edit using the Template Selections or Search/Browse tab.
2. Select the desired template.
3. Click **View/Edit** on the Action bar. The Template Details tab displays.

Figure 42–12: Template Management Module—Template Details Tab

4. Add or remove information in the following fields, as necessary:
 - Associated Reasons for Visit
 - Associated Problems
 - Diagnoses
 - Notes Templates
 - Other Therapies
 - Associated Appointment Types
 - Items to AutoCite into Note
 - Procedures
5. Click **Save** on the Action bar.

Tip:
Click **Save As** to
save the template
under a new name.

42.9 Merging Templates

Templates can be combined to create a completely new template.

Follow the steps below to merge templates:

1. Search for the templates you want to merge. The templates appear in the Search/Browse tab.

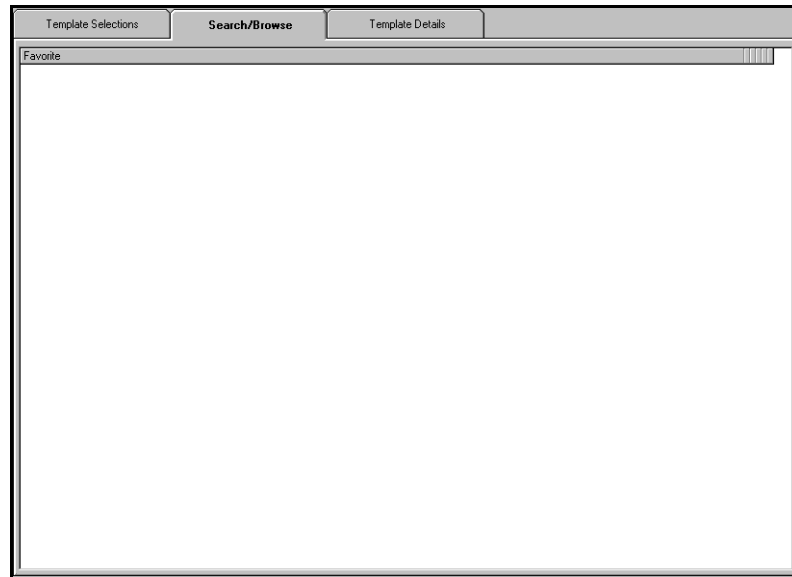


Figure 42-13: Template Management Module – Search/Browse Tab

2. Select the templates by pressing the **Ctrl** key on your keyboard and clicking on each template you want to merge.
3. Click **Merge** on the Actions menu. The Template Details tab displays the details from the selected templates.
4. Edit the template if necessary.
5. Click **Save As** on the Action bar. The Save Encounter Template window opens.

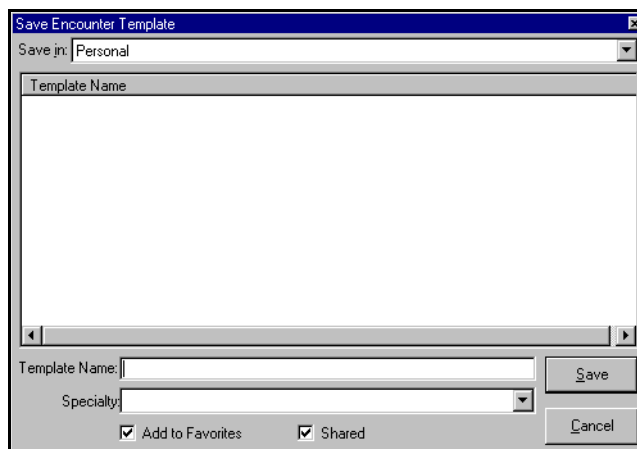


Figure 42-14: Save Encounter Template Window

6. Select a template type from the Save in drop-down list.
7. In the **Template Name** field, enter the template name.
8. Select a Specialty from the drop-down list.
9. Select the checkbox to denote whether the template should be added to the Favorites List or shared with other Clinical Team members.

10. Click **Save** to save the template.

42.10 Copying a Template

A current template can be copied, edited, and renamed to create a new template.

Follow the steps below to copy a template:

1. Search for the template you want to copy.
2. Select the template in the Search/Browse tab.
3. Right click and point to **New Template** and then click **Copy from Selection**. The Template Details tab displays with the selected template details.
4. Edit the template if necessary.
5. Click **Save As** on the Action bar. The Save Encounter Template window opens.
6. Select a template type from the Save in drop-down list.
7. In the **Template Name** field, enter the template name.
8. Select a Specialty from the drop-down list.
9. Click the checkbox to denote whether the template should be added to the Favorites List or shared with other Clinical Team members.
10. Click **Save** to save the template.

Tip:

The title of the template changes to Copy of ...(selected template).

42.11 Removing/Adding to Favorites

Templates can be added to the Favorites List to be seen as suggested templates for every encounter. A template search can also be conducted with only the Favorites List. Templates can be added to or removed from the Favorites List from either the Template Selections or Search/Browse tab.

Follow the steps below to add a template to the Favorites List:

1. Search for the template you want to add.
2. Select the template in the Search/Browse tab.
3. Click **Add Favorite** on the Action bar. The Favorite column on the Search/Browse tab changes from No to Yes and the template is added to My Favorites folder on the Template Selections tab.

Follow the steps below to remove a template from the Favorite List:

1. Search for the template you want to remove.
2. Select the template in the Search/Browse tab.
3. Click **Remove Favorite** on the Action menu.
4. At the confirmation prompt, click **Yes**.

42.12 Importing/Exporting a Template

A template can be imported from or exported to an electronic storage device for use at another location. All of the details of the template are included when it is imported or exported. Since the template contains all details, the order sets included are specific to the originating clinic. If the template is imported/exported to another clinic or host location, the orders are deleted upon import. You can import/export a template from the Template Selections or Search/Browse tab.

Follow the steps below to import a template:

1. Click **Import** on the Action bar. The Import Encounter Template window opens.

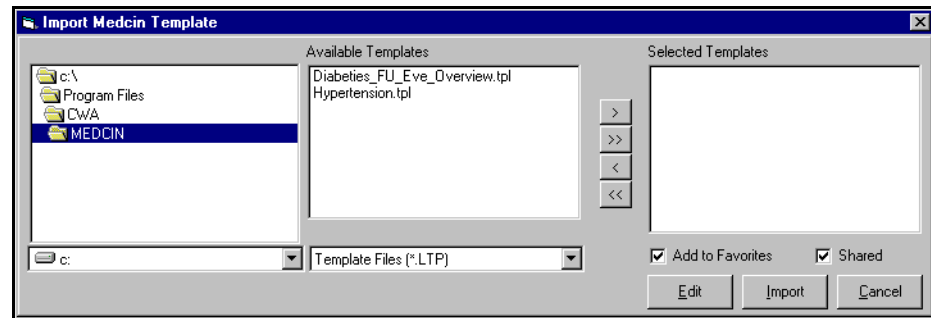


Figure 42–15: Import Encounter Template Window

2. Select a template from the Available Templates list.

Note: If the template is not in the defaulted folder, browse to the folder where the templates are located.

3. Click the **arrow buttons** to move the selections to the Selected Templates list.
4. Do one of the following:
 - If you want to edit the selected template before you save it:
 - a. Click **Edit**. The Template Details tab displays with the details of the imported template.
 - b. Add or remove information in the following fields:
 - Associated Reasons for Visit
 - Associated Problems
 - Diagnoses
 - Notes Templates
 - Other Therapies
 - Associated Appointment Types
 - Items to AutoCite into Note
 - Procedures

- If you want to import the template as is, click **Import**. The Template Details tab displays with the details for the imported template.
5. Click **Save As** on the Action bar. The Save Encounter Template window opens.
 6. Select a template type from the Save in drop-down list.
 7. In the **Template Name** field, enter the template name.
 8. Select a Specialty from the drop-down list.

Note: Click **Add to Favorites** if you want the template to be added to the Favorites list to be shared with other Clinical Team members.

9. Click **Save**.

Follow the steps below to export a template:

1. Search for the template you want to export.
2. Select the template from the Search/Browse tab.
3. Click **Export**. The Export Encounter Template window opens.

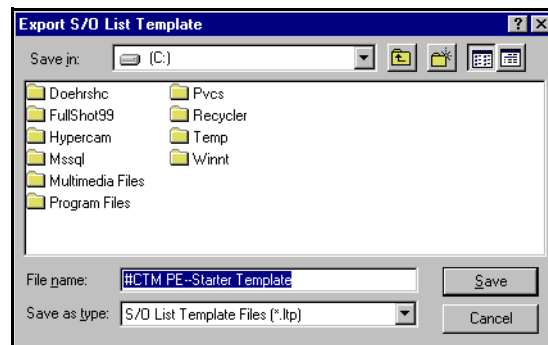


Figure 42–16: Export Encounter Template Window

4. Browse to the folder location where you want to export the template.
5. Click **Save**.

42.13 Deleting a Template

A template can be deleted from the Search/Browse tab.

Follow the steps below to delete a template:

1. Search for the template you want to delete.
2. Select the template from the Search/Browse tab.
3. Click **Delete** on the Action menu.
4. At the delete confirmation prompt, click **Yes**.

42.14 Saving an Encounter as a Template

After an encounter has been documented, the structure can be saved as an encounter template. No patient-specific information is saved. This action can be performed from the Patient Encounter and Previous Encounter modules.

Follow the steps below to save an encounter as a template:

1. Document the encounter.
2. On the Actions menu, click **Save As Template**. The Template Details tab on the Template Management module opens.

The screenshot displays the 'Template Details' tab within the Template Management module. The interface includes a header with 'Template Selections', 'Search/Browse', and 'Template Details' tabs. Below the header, there are input fields for 'Template Name' (VISIT-URI COMPLETE), 'Owner Type' (Personal), 'User' (PROVIDER, JOHN), 'Specialty', and 'EM Code Category'. The main area is divided into several sections, each with an 'Add...' and 'Remove' button: 'Associated Reasons for Visit', 'Associated Appointment Types' (containing 'WALK'), 'Associated Problems', 'Items to Autocite into Note', 'Diagnoses' (listing ACUTE BRONCHITIS 466.0, COMMON COLD 460, OTITIS MEDIA 382.9, PHARYNGITIS 462, and UPPER RESPIRATORY INFECTION 465.9), 'Procedures' (listing Electrocardiogram 93000 and Pulmonary Function Tests Peak Flow 94150), 'Notes Templates' (listing [List] VISIT-URI), 'Orders' (listing MedjAMOXICILLIN-PO 500MG CAP, MedjAZITHROMYGIN (ZITHROMAX)-PO 250MG CAP, MedjALBUTEROL (PROVENTIL)-INH 0.5% SOLN, (Lab)COMPLETE BLOOD COUNT, and (Rad)CHEST, PA AND LATERAL), and 'Other Therapies' (listing Return To Clinic If Worse Or New Symptoms and Oral Fluids).

Figure 42–17: Template Management module—Template Details Tab

3. Select an owner type from the drop-down list, if necessary.
4. Select a specialty from the drop-down list, if necessary.
5. Select an E&M code category from the drop-down list, if necessary.
6. Add or remove information from the following areas:
 - Associated Reasons for Visit
 - Associated Problems
 - Diagnoses
 - Notes Templates
 - Other Therapies
 - Associated Appointment Types
 - Items to AutoCite into Note
 - Procedures
7. Click **Save As** on the Action bar. The Save Encounter Template window opens.

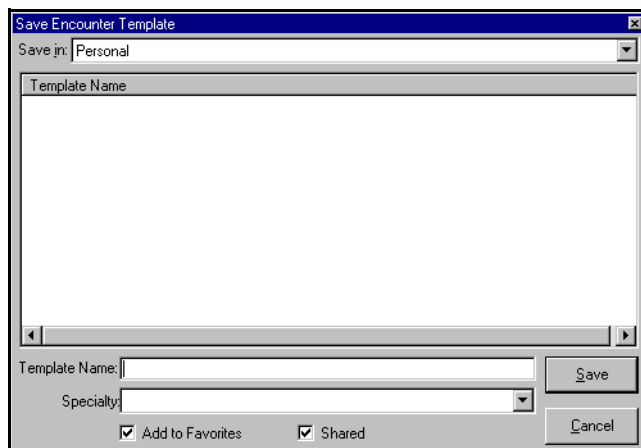


Figure 42-18: Save Encounter Template Window

8. Select the template type from the Save-in drop-down list.
9. In the **Template Name** field, enter the template name.
10. Select the specialty from the drop-down list.
11. Select the checkboxes to denote whether the template should be added to the Favorites List or shared with other Clinical Team members.
12. Click **Save**.

43.0 CHCS II TRAINING SYSTEM

43.1 CHCS II Training System Overview

The CHCS II Training System (CTS) is a stand-alone training application. The goal of this tool is to enable you to participate in the CHCS II courses that teach you the skills you need to perform your assigned duties as well as practice on your own. The Training System contains staged data to help you through your course and assist you in understanding CHCS II functionality.

The CHCS II Training System contains the same core functionality available in CHCS II; however, interface capabilities between CHCIS II and components (e.g., CHCS) are simulated to produce a realistic data exchange process. The Training System is not role based—users, regardless of their clinic roles and responsibilities, have access to the same functionality.

You can differentiate between CHCS II and the Training System by the Patient ID bar and the “Training Use Only” watermark. The Training System uses a green Patient ID bar and CHCS II uses a gray Patient ID bar.

Note: If the user has modified their computer’s color scheme, the Patient ID bar color may not appear in green or gray. It is recommended that users keep the default color scheme.

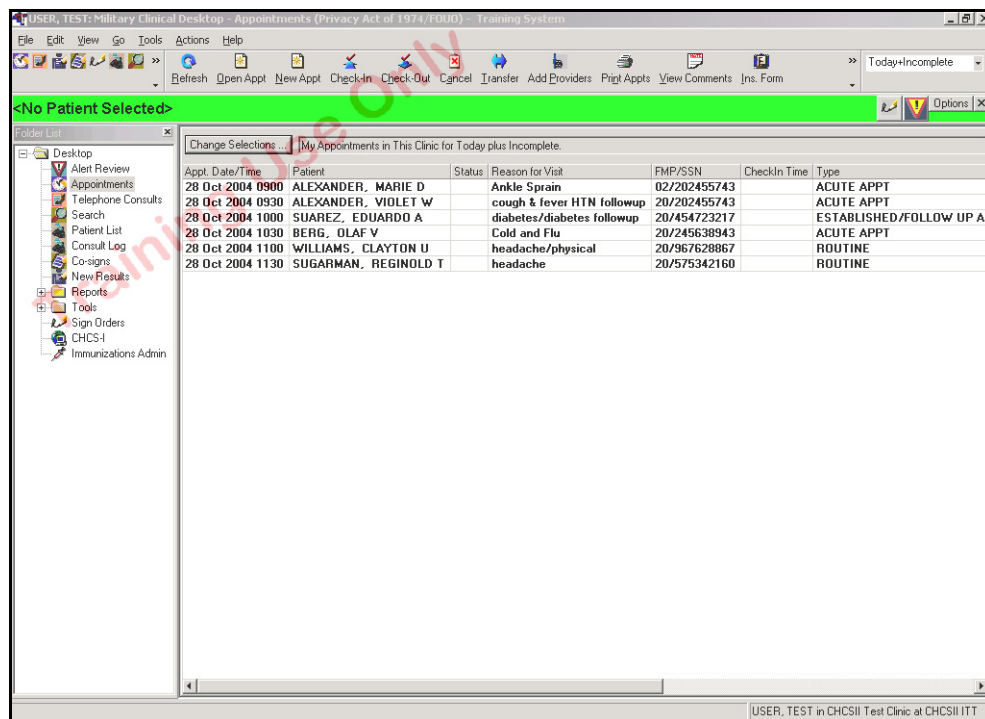


Figure 43-1: CTS Appointments Module

Note: Performing an auto-update from build 833.8 to 837.2 will not load the training system. Once the auto-update is complete, additional files must be installed. These files are located in the Support folder. Double-click **CTS_AddOn.exe** to install the training system for build 837.2. In the future, the auto-update will provide the latest version of the live system, as well as the training system. Refer to section 5.2 of the System Installation Guild Clinical Workstation, Version 2.59.1, dated 24 September 2004, for complete instructions on loading the training system on your CWS. If you elect NOT to install the training system with build 837.2, future CHCS II releases will not provide the procedures described above, and a complete un-install re-install will need to be performed to load both the training system and the live system on the CWS. Subsequently, you may use auto-update, and both the live system and the training system will be updated.

43.2 Logging into the Training System

The Training System is built with an automatic login.

Follow the steps below to login to the Training System:

1. Double-click the CTS icon on your desktop.



Figure 43-2: Training System Icon

2. First, you are asked to choose a training clinic (Medical, Dental, SRTS II). This specifies which role you will assume. Select the appropriate clinic from the list and click **OK**.
 - **Medical:** Assumes the role of a Provider.
 - **Dental:** Assumes the role of a Dental Provider.
 - **SRTS II:**

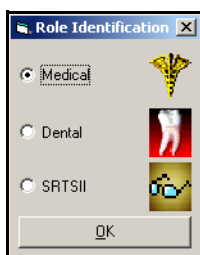


Figure 43-3: Role Identification Selection Window

3. Read the purpose statement on the first splash screen and click the small **x** in the top, right corner or press **Esc** on your keyboard.

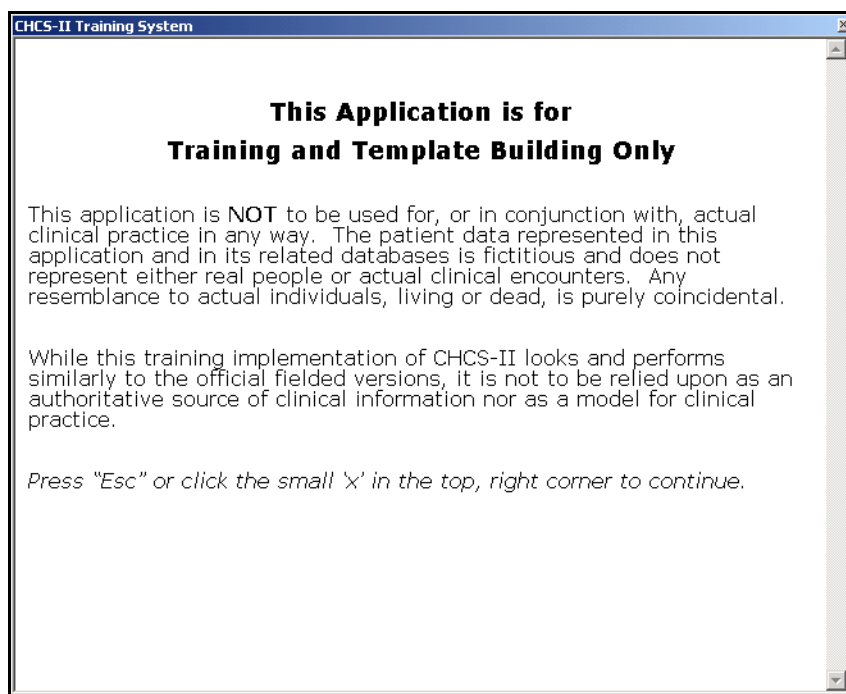


Figure 43-4: Purpose Statement

4. The second splash screen highlights the functionality of the Training System. Again, click the small x in the top, right corner or press **Esc** on your keyboard.

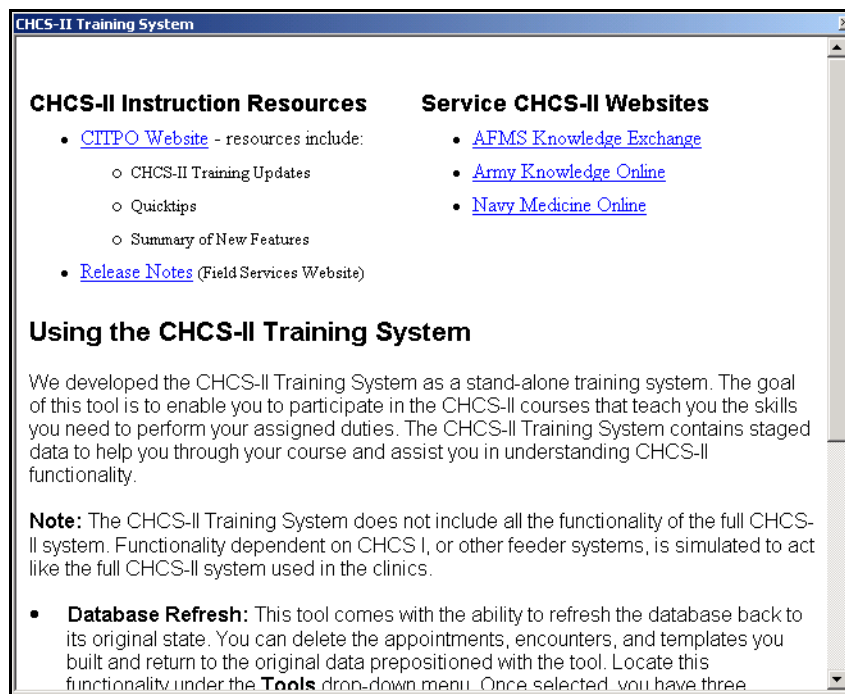


Figure 43-5: Training System Functionality Statement

5. The Training System moves through the automatic logon.

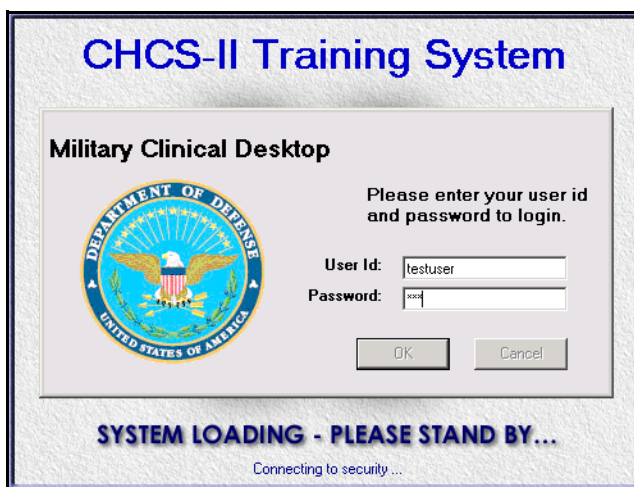


Figure 43-6: Automatic Logon

6. Once complete, the application opens to the Appointments module.

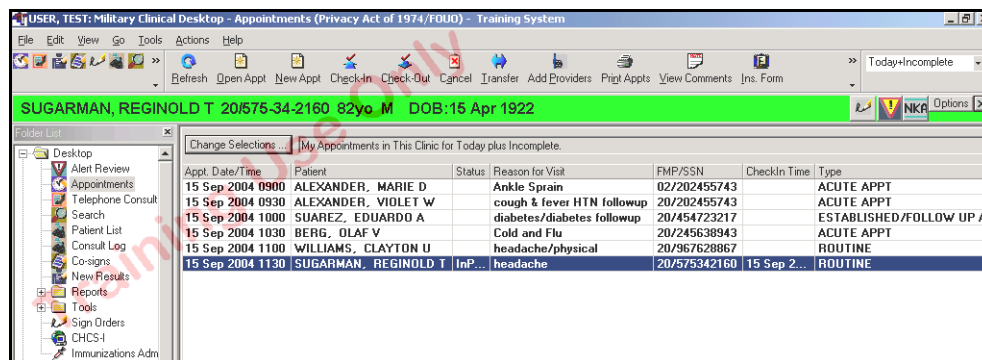


Figure 43-7: Appointments Module

The Training System allows you to assume only one role at a time. Therefore, if you need to use the Training System for a different role, you need to log out of the application, then logon again, choosing the appropriate role as in step #2 above. You should also reset the Training System database before proceeding.

43.3 Using the Training System

Once logged in, the Training System works similarly to the CHCS II application. The sections below highlight some of the features of the Training System.

43.3.1 Training System Database

The Training System comes with two databases. One database houses all the prepositioned information relative to the appointments, patients, templates, and encounters. The first time you log into the Training System, this information is available and ready for use.

The second database is used as you navigate through the application and make changes or additions to the original baseline database. Information you add or modify (appointments, templates, or patient information), is stored within this database.

43.3.2 Database Reset

The Training System comes with the ability to reset the database to the original baseline. You can delete the appointments, encounters, and templates you created and return to the original baseline data prepositioned with the system.

Follow the steps below to reset the database:

1. Select the **Tools** menu.
2. Select **Training System Database Reset**.
3. You have three options from which to choose. Click **Templates, Encounter Data, or Entire Database**.

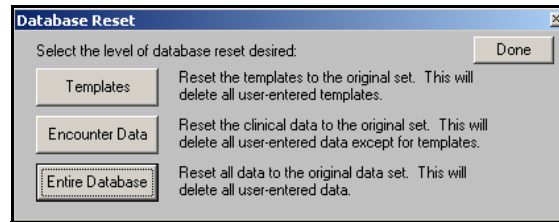


Figure 43-8: Reset Options

4. Upon completion, click **Done**. The Training System closes and returns to the desktop.

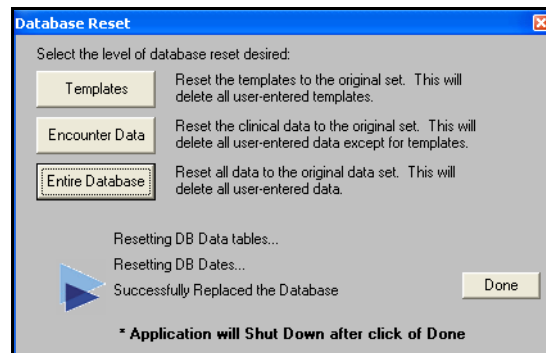


Figure 43-9: Reset Complete

5. Log back in to the Training System to begin using the application.

43.3.3 Locking the Training System

If you want to leave the workstation you may lock your session by pressing **Ctrl + Z** on your keyboard. Your session remains locked until you click **OK**.

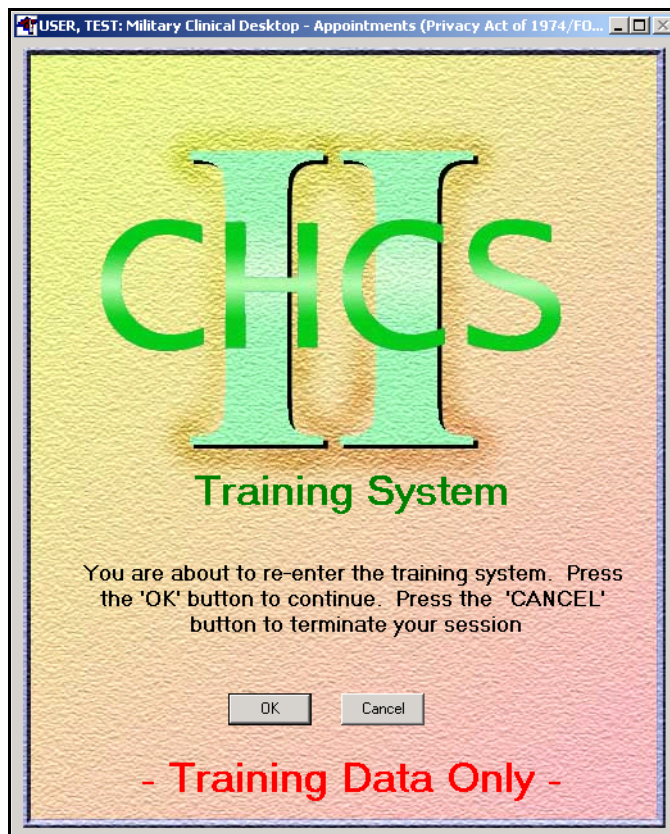


Figure 43–10: CTS Lock Out Screen

Note: The CTS lock out screen is visually different from the CHCS II lock out screen. Notice also that unlike the CHCS II lock out screen, a password does not need to be entered to unlock the session.

43.3.4 Appointments

The Appointments module is the default module to be viewed upon login. Prepositioned appointments, located in the baseline database, are immediately available for medical, dental and SRTS II training. The default date of the appointments is the date of installation or reset. So, if the Training System is installed on March 1, the prepositioned appointments is not visible on March 2nd unless the filter is changed.

43.3.5 MEDCIN (S/O) Starter Templates

The Training System is loaded with starter MEDCIN (S/O) templates. Use these as a beginning point when building your own, customized templates.

Follow the steps below to access the MEDCIN starter templates:

1. Open a patient encounter.

2. Click **S/O** from the Patient Encounter module.
3. Click **Template Mgt.** in the Action bar.
4. Expand the **My Favorites** folder to view the available templates.

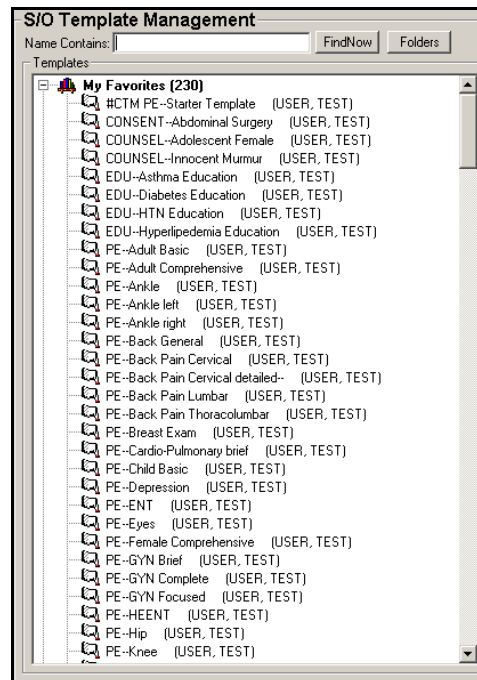


Figure 43–11: MEDCIN Templates

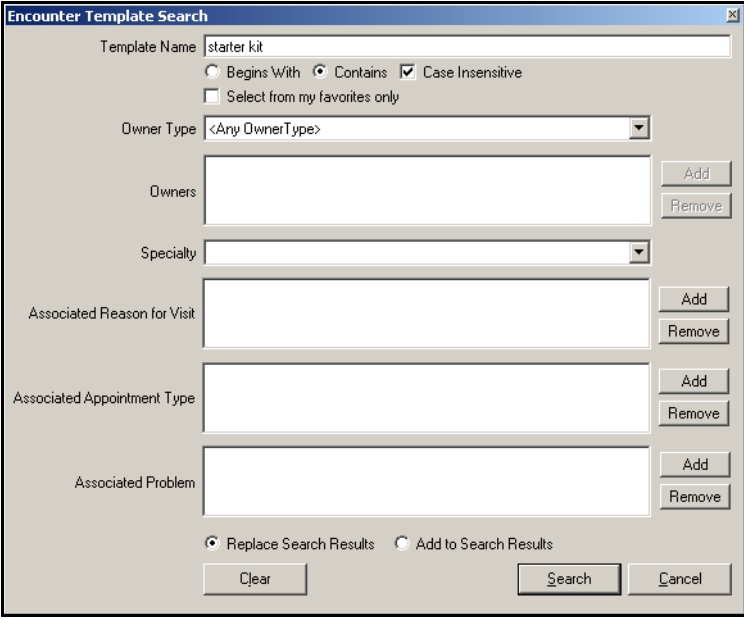
The starter templates are organized by component and type (ex: Well Child templates). Load and use any of the starter templates as a beginning point when customizing your own templates.

43.3.6 Encounter Starter Templates

The encounter starter templates are located in the Template Management module. From the Search/Browse tab, perform a search for templates that include the words *starter kit*.

Follow the steps below to access the Encounter Starter Kit Templates:

1. Click on the + next to the Tools folder in the Folder List.
2. Click **Template Management** from the Folder List.
3. On the Search/Browse tab, click **Search** from the Action bar.
4. In the Template Name field, enter *starter kit*.



The **Encounter Template Search** dialog box contains the following fields and controls:

- Template Name:** A text field containing "starter kit".
- Search Options:**
 - ☐ Begins With
 - ☒ Contains
 - ☒ Case Insensitive
 - ☐ Select from my favorites only
- Owner Type:** A dropdown menu showing "<Any OwnerType>".
- Owners:** A list box with an **Add** button and a **Remove** button.
- Specialty:** A dropdown menu.
- Associated Reason for Visit:** A list box with **Add** and **Remove** buttons.
- Associated Appointment Type:** A list box with **Add** and **Remove** buttons.
- Associated Problem:** A list box with **Add** and **Remove** buttons.
- Search Action:**
 - ☒ Replace Search Results
 - ☐ Add to Search Results
- Buttons:** **Clear**, **Search**, and **Cancel**.

Figure 43–12: Encounter Template Search

- Click **Search** to view all of the Encounter Starter Kit Templates. Load and use any of the starter templates as a beginning point when customizing your own templates.

Template Selections		Search/Browse		Template Details	
Template Name	ID	Scope	Owner	Shared	Favorite
Abd Pain_starter kit	1139	Clinic	CHCSII ITT HC2T	Yes	No
Abnormal Vaginal Bleeding_starter kit	1140	Clinic	CHCSII ITT HC2T	Yes	No
Allergic Rhinitis_starter kit	1141	Clinic	CHCSII ITT HC2T	Yes	No
Ankle Sprain Left_starter kit	1142	Clinic	CHCSII ITT HC2T	Yes	No
Ankle Sprain Right_starter kit	1143	Clinic	CHCSII ITT HC2T	Yes	No
Asthma_starter kit	1144	Clinic	CHCSII ITT HC2T	Yes	No
Breast Mass_starter kit	1145	Clinic	CHCSII ITT HC2T	Yes	No
Depression_starter Kit	1146	Clinic	CHCSII ITT HC2T	Yes	No
Diabetes_starter kit	1147	Clinic	CHCSII ITT HC2T	Yes	No
HTN_starter kit	1148	Clinic	CHCSII ITT HC2T	Yes	No

Figure 43–13: Encounter Starter Kit Templates

43.4 Patient Information

The Training System contains patients of various ages and ailments. The system is populated with a male and a female patient that match the critical stages of development.

Certain patients have associated clinical data (lab and rad results, problems, medications).

43.4.1 Patient Search–Training System Functionality

The Patient Search module contains two features that are not part of CHCS II. One is the All Patients feature and the other is Patient Details.

- **All Patients:** Allows you to view all the patients in the Training System database
- **Patient Details:** Allows you to view all the patient-specific information (age, associated clinical data)

Follow the steps below to locate patients in the Training System database:

1. Click **Search** from the Folder List to view the Patient Search window.
2. Click **All Patients** to view all the patients in the database.

The screenshot shows the 'Patient Search' window. It has a top section with search filters: Quick Search, Last Name, First Name, DOB, UIC, SSN, FMP, Sponsor SSN, and Sex. There are buttons for 'Find', 'New Search', 'All Patients', 'Edit Patient', 'Search CHCS', and 'Patient Details'. A checkbox at the bottom left says 'Find only patients enrolled in this facility.' Below the filters is a table with patient information.

Patient Name	SSN	FMP/Sponsor SSN	DOB
ALEXANDER, EDWARD P	213-55-4232	01/202-45-5743	25 Jan 1985
ALEXANDER, EVELYN L	647-09-7621	03/202-45-5743	07 Jun 2000
ALEXANDER, MARIE D	213-56-4211	02/202-45-5743	25 Jan 1985
ALEXANDER, SAMANTHA R	000-00-0030	04/202-45-5743	05 Jun 2002
ALEXANDER, VIOLET W	202-45-5743	20/202-45-5743	07 Jul 1957
BERG, LEE T	000-00-0029	01/245-63-8943	18 Jan 2002
BERG, OLAF V	245-63-8943	20/245-63-8943	25 Mar 1947
CHANG, ESTER M	788-27-9046	03/732-67-9231	18 Feb 2001
CHANG, INDIRA L	000-00-0026	02/732-67-9231	15 Jan 2002
CHANG, JON S	732-67-9231	20/732-67-9231	19 Oct 1967
CHANG, MAMDOUH R	789-56-5577	01/732-67-9231	03 May 1997
CLOUD, APRIL	000-00-0028	03/645-21-0058	19 Jun 2002
CLOUD, HEATHER	645-21-0058	20/645-21-0058	08 Dec 1967
CLOUD, LANCE	877-32-8112	02/645-21-0058	08 Jun 1994
CLOUD, ROSE	536-65-2118	01/645-21-0058	11 Oct 1989
MARCOS, FREDERICK B	532-97-3621	01/013-97-9876	12 Mar 2001
MARCOS, RAMONA D	013-97-9876	20/013-97-9876	10 Jun 1947
SUAREZ, RONITA S	000-00-0024	40/454-72-3217	15 Jan 1922

At the bottom of the window are 'OK' and 'Cancel' buttons.

Figure 43-14: All Patients

3. Click **Patient Details**. A table displays with all the patient information in the search results area.
4. Review the details.

Patient Search

Quick Search: SSN: **Find**

Last Name: FMP: **New Search**

First Name: Sponsor SSN: **All Patients**

DOB: Sex: **Edit Patient**

UIC: **Search CHCS** **Patient Details**

☐ Find only patients enrolled in this facility.

	A	B	C	D	E	
	Name	SSN	Sponsor SSN	Race	Age	S
1						
2						
3	Wunderlich, Gertha M.	000-00-0023	818-11-8118	Caucasian	< 24 hours	F
4	Cloud, April	000-00-0028	645-21-0058	Native American	< 24 hours	M
5						
6	Alexander, Samantha R	000-00-0030	202-45-5743	Black	2 weeks	F
7	Suarez, Jose Q	000-00-0031	454-72-3217	Hispanic	2 weeks	M
8						
9	Chang, Indira L	000-00-0026	732-67-9231	SE Asian	6 months	F
10	Berg, Lee T	000-00-0029	245-63-8943	Asian	6 months	M
11						
12	Chang, Ester M	788-27-9046	732-67-9231	Black, Hispanic	1 year	F
	Marcos data	532-97-3621	013-97-9876	White	1 year	M

OK **Cancel**

Figure 43-15: Patient Details

Note: To perform a search after viewing patient details, click **Cancel**.

43.5 Removing the Training System

Since the Training System is now part of CHCS II, you cannot remove the Training System without removing CHCS II. When removing CHCS II and the Training System from your workstation, use the standard Windows Add/Remove function.

Follow the steps below to remove CHCS II and the Training System:

1. On your workstation desktop, select **Start**, point to **Settings**, and then click **Control Panel**.
2. Double-click **Add/Remove Programs**.
3. Click the **CHCS II** listing and then click **Remove**.
4. Click **Yes** at the prompt.
5. The InstallShield Wizard removes CHCS II and the Training System from your computer. Click **Finish** when the task is complete.

44.0 VITAL SIGNS

44.1 Vital Signs Overview

The Vitals Sign module enables you to view, edit, delete, and add vital signs information for a patient. The Vital Signs module can be accessed in two different areas on the Folder List, under Health History and under Current Encounter. If Vital Signs (Review) is accessed under Health History, only past vitals can be reviewed. If Vital Signs (Entry) is accessed through the current encounter, vital signs can be reviewed, entered, edited, or deleted.

The screenshot shows the 'Vital Signs Module (Entry Tab)' window. At the top, there are buttons for 'Clear Vitals', 'Save Vitals', 'S/D', and 'Close'. A patient identifier bar shows '0/202-45-5743 47yo F Col DOB:07 Jul 1957' and an 'NKA Options' button. Below this is a 'Review | Entry' tab bar. The main area contains several input sections: 'Date' (05 Oct 2004 12:00) with checkboxes for 'Visual Acuity', 'Oxygen Sat.', and 'Peak Flow'; 'Standard Vital Signs' with fields for BP, HR, RR, and Temperature; 'Height/Weight' with fields for Ht, Wt, BMI, and BSA; 'Habits' for Tobacco and Alcohol; 'Visual Acuity' for Right, Left, and Both eyes (Uncorrected and Corrected); 'Oxygen' for Oxygen Saturation; 'Peak Flow' for Peak Flow; and 'Pain Severity' with a scale from 0 to 10. There is also a 'Comments' text area and a 'Where is the Pain Located?' section. At the bottom are 'OK' and 'Cancel' buttons.

Figure 44-1: Vital Signs Module (Entry Tab)

44.2 Setting the Properties of the Vital Signs Module

When accessing Vital Signs (Review) under Health History in the Folder List or a current encounter, you can customize the default settings for both the Entry and Review tabs.

Follow the steps below to set the properties of the Vital Signs module:

1. In the Vital Signs workspace, click **Options** in the upper, right corner. The Properties window opens.

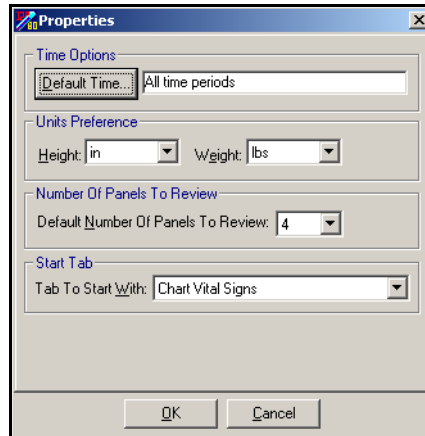


Figure 44-2: Vital Signs – Properties Window

2. Set the following preferences:
 - **Default Time:** Click **Default Time** to view the Time Search window. Select the desired option for the date range of the records to be viewed on the Review tab. Searches include: All Time Periods, Last ‘N,’ Sliding Time Range and Specific Time Period.
 - **Height and Weight:** Using the drop-down lists, select the Height and Weight units displayed in the Entry tab.
 - **Default Number of Panels to Review:** Use the drop-down list to select the desired number of panels to be reviewed in the Review tab.
 - **Tab to Start With:** Use the drop-down list to select the tab that appears when you open the Vital Signs module.
 - **Chart Vital Signs:** Entry Tab
 - **Review Vital Signs:** Review Tab
3. Click **OK** to save the selected settings as the default settings.

Note: The new settings will take effect after you close the Vital Signs module.

44.3 Entering New Vital Signs

The Entry tab allows vital signs to be entered under three different categories:

- Adult
- Obstetric (Female Only Patients)
- Pediatric

The default view is Adult, which displays Standard Vital Signs, Height/Weight, and Tobacco Use. Selecting either **Obstetric** or **Pediatric** brings up additional panels specific to their respective category. Vital signs must be entered in the Current Encounter Vital Signs (Entry) module in an open encounter.

Follow the steps below to enter new vital signs:

1. Open a patient encounter.
2. In the Encounter Summary module (electronic SF600), click **Vitals**. The Vital Signs module opens and the Entry tab is displayed by default.

Tip:

You can also access the Vitals module by opening the Current Encounter folder and clicking **Vital Signs (Entry)** on the Folder List.

Figure 44–3: Vital Signs Entry Module—Entry Tab

3. Select the category for which you are entering vitals from the drop-down list to the right of the Action bar.

Note: The default is Adult. The Obstetric option, for female patients, includes the adult panels plus the Urine Dip Stick panel. The Pediatric option includes the adult panels plus the Head Circumference panel and a Pediatric Pain Scale.

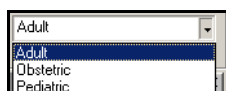


Figure 44–4: Vital Signs Categories

4. Select the checkbox for any of the following to display additional vital sign input fields, if necessary:
 - Visual Acuity
 - Oxygen Saturation
 - Peak Flow

Figure 44–5: Vitals Module—Entry Tab

5. Enter the correct data in the following fields and tab to the next field.
 - **Standard Vital Signs:** Enter blood pressure, heart rate, respiratory rate and temperature (in Celsius or Fahrenheit). The **Blood Pressure** and **Heart Rate** fields allow you to add modifiers. Click **Display Orthostatic** if you want to enter orthostatic vital signs for the patient.
 - **Habits:** Select the radio button to denote the usage of tobacco and/or alcohol. Clicking the **Yes** radio button activates the Ellipsis button. Click the **Ellipsis** button to document the frequency/duration.

Figure 44–6: Tobacco Frequency/Duration Window

Frequency/Duration

Alcohol Usage:

1. Have you ever felt you should Cut down on your drinking? ☐ Yes ☐ No

2. Have people Annoyed you by criticizing or complaining about your drinking? ☐ Yes ☐ No

3. Have you ever felt bad or Guilty about your drinking? ☐ Yes ☐ No

4. Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No

Enter Frequency/Use/Duration Comments:

OK
Cancel
Reset

Figure 44–7: Alcohol Frequency/Duration Window

- **Height/Weight:** Enter patient height information in inches, feet, or centimeters and weight in pounds, ounces, grams, or kilograms. The height and weight can be entered using decimals (i.e., 75.6). You can add modifiers to both the height and weight categories. The system automatically calculates the Body Mass Index (BMI) and the Body Surface Area (BSA).
- **Comments:** Enter any comments.

Note: If the data is abnormal, a Vital Sign Range Warning appears. Click **Yes** to continue with the entered data. Click **No** to go back and re-enter the data.

Note: Click the **Ellipsis** button to add modifier information to the associated vital sign.

6. Click **OK** to save the vitals or click **Save Vitals** on the Action bar.

44.4 Editing Vital Signs

You can only edit vital signs for the current encounter.

Follow the steps below to edit vital signs:

1. On the Review tab, select the vital signs you want to edit.
2. Click **Edit Vitals** on the Action bar. The Entry tab automatically opens.

Note: The Edit Vitals option is not available if you access the Vital Signs (Review) module under the Health History folder on the Folder List.

3. Enter any additional comments or add any values in the following areas:
 - Standard Vital Signs

- Habits
 - Height/Weight
 - Comments
 - Visual Acuity
 - Oxygen Saturation
 - Peak Flow
 - Pain Scale
4. Click **OK** to save the information. The edits are documented in the Change History portion of the Encounter Document.

44.5 Deleting Vital Signs

You can only delete vital signs for the current encounter.

Follow the steps below to delete vital signs:

1. On the Review tab, select the vital signs you want to delete.

The screenshot shows the 'Review' tab of the Vital Signs Entry Module. At the top, there are tabs for 'Review' and 'Entry'. Below them is a search bar labeled 'SearchType...' and a dropdown menu for 'All time periods'. A 'Refresh' button is on the right. The main area contains a table with the following data:

Date	BP	HR	RR	T	Tobacco	BMI	BSA
11/20/2001 1545	130/80	65	35	99	Yes	25.09	2.061
10/18/2001 1118	120/70	55	20	98.6	Yes		
10/12/2001 0856	160/70	55	17	98.6	Yes		
7/10/2001 1524				98.6	No		
6/26/2001 1648	120/70	65	21	102	No		
6/1/2001 0846	180/70	55	17	98.6	No		
4/2/2001 1411	130/70	57	25	99	Yes	23.06	1.988

Below the table is a large empty space. At the bottom, there is a section labeled 'Vitals' with the following text:

Written by: PROVIDER, CHRISSY @ 20 Nov 2001 1545 EDT
 BP: 130/80 Adult Cuff, Right Arm, HR: 65, RR: 35, T: 99 F Otic, HT: 72 in, WT: 185 lbs, BMI: 25.09, BSA: 2.061 square meters, Tobacco Use: Yes,
 Would you like to quit? No, Alcohol Use: Yes, Do you annoy others? No, Do you want to cut down? No, Do you need an eye opener? No,
 Do you feel guilty? No

Figure 44-8: Vital Signs Entry Module (Review Tab)

2. Click **Delete Vitals** on the Action bar. A confirmation message appears.
3. Click **Yes**. The deletion is documented in the Change History portion of the encounter summary module.

44.6 Graphing Vital Signs

You can only graph vital signs for a current encounter.

Tip:

The **Delete Vitals** option is not available if you access the **Vital Signs (Review)** module under the **Health History folder** on the **Folder List**.

Follow the steps below to graph vital signs:

1. On the Review tab, select the set of vitals you want to graph.
2. Click **Graph Vitals** on the Action bar. The Graph Vitals window opens.

Tip:

More than one set of vital signs must be selected to generate the graph.

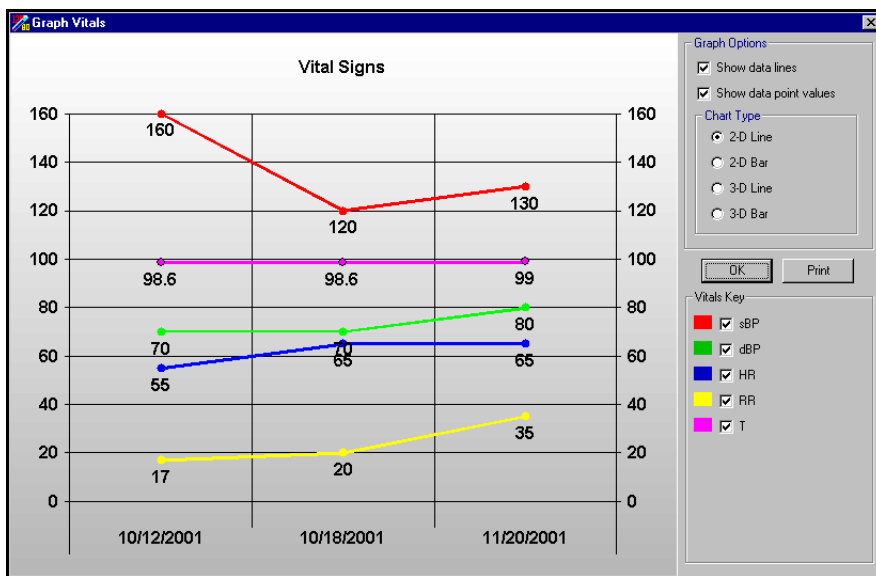


Figure 44-9: Graph Vitals Window

3. Select the checkbox(es) to change the graph options, if necessary. The default displays both data lines and data point values.
4. Select the radio buttons to change the chart type, if necessary. The default displays the chart in a 2-D line.
5. Click **Print** to print the current graph.
6. Click **OK** to close the Graph Vitals window and return to the Vital Signs module.

44.7 Reviewing Vital Signs

Follow the steps below to review past vital signs:

1. On the Review tab, view past vital sign information.
2. Do one of the following:
 - If you want to customize the number of vital sign entries listed in the tab:
 - a. Click **Search Type**. The Time Search window opens.

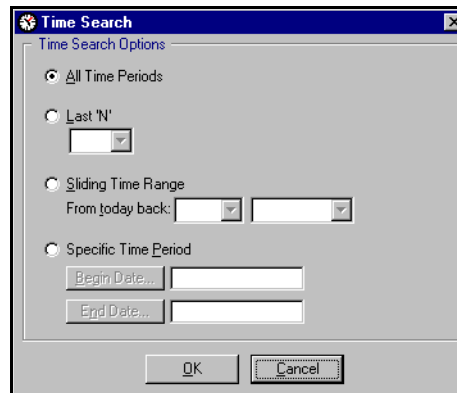


Figure 44–10: Time Search Window

- b. Select the desired time option.
 - c. Click **OK**. The entries meeting the search criteria appear in the tab.
- If you want to view details on a specific set of vital signs:
 - a. Select the set of vital signs for which you want to view detailed information.
 - b. The details populate the text field in the bottom of the tab.
- If you want to change the unit of temperature values for a set of vitals:
 - a. Select the set of vital signs.
 - b. Click the **Temp** toggle button on the Action bar.

44.8 Vital Sign Ranges

The following are valid ranges for entering vital signs information.

Vital Signs	Ranges
Blood Pressure:	
Systolic	80–200 mm Hg
Diastolic	Must be less than systolic and 40–120 mm Hg
Heart Rate	40–150 Beats per minute
Respiratory Rate	5–40 breaths per minute
Temperature	95–105° F
Height	12–84 inches
Weight	1–350 pounds
Visual Acuity	10–999
Oxygen Saturation	70–100 percent
Peak Flow	40–650 liters per min
Head Circumference (Pediatric)	10–22 inches
Pain Sensitivity	Adult: 0–10 (with 0 being pain free and 10 being totally disabling) Child: 0–5 (with 0 being no hurt and 5 being hurts worst)

Note: If you enter a vital range that is out of the ordinary, a warning window appears. Click **Yes** to accept the vital sign entry, or click **No** to re-enter the vital sign.

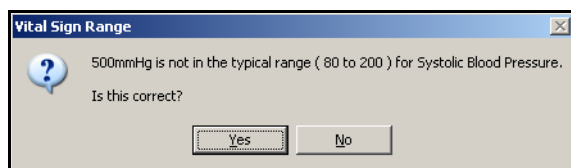


Figure 44–11: Warning Window

45.0 WEB BROWSER

45.1 Web Browser Overview

CHCS II is installed with the Internet Explorer Web Browser. This functionality enables you to access the Internet for the purpose of researching information from a variety of favorite medical sites without exiting CHCS II. Because the Web Browser is contained within CHCS II, the application does not time out while searching the Internet. Navigation in the Web Browser is done through the Action bar.



Figure 45-1: Military Clinical Desktop—Web Browser

45.2 Changing the Internet Home Page

Once the Web Browser has been accessed, the internet home page is displayed in the Workspace. The internet home page can be changed according to individual preference.

Follow the steps below to change the Internet home page:

1. On the Windows Task bar, click **Start**.
2. Point to Settings and click **Control Panel**. The Control Panel window opens.

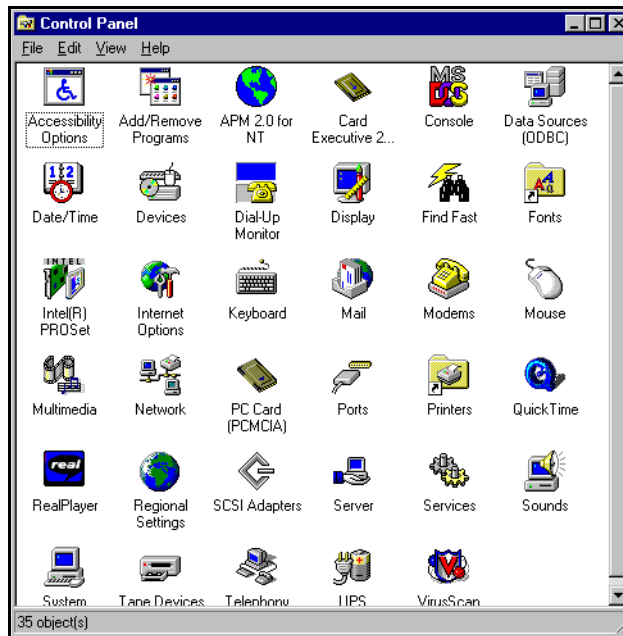


Figure 45-2: Control Panel

3. Double-click **Internet Options**. The Internet Properties window opens with the General tab defaulted.



Figure 45-3: Internet Properties Window

4. In the Home Page area enter the desired URL in the Address field.
5. Click **OK**. This is the webpage that displays when you access the Web Browser. Click **Home** on the Action bar to return to the home page at any time.

45.3 Accessing the Favorites List

The Favorites list is a shortcut to Internet sites that are frequently accessed.

Follow the steps below to access the favorites list:

1. Click **Favorites** on the Action bar. The Goto Favorite window opens.

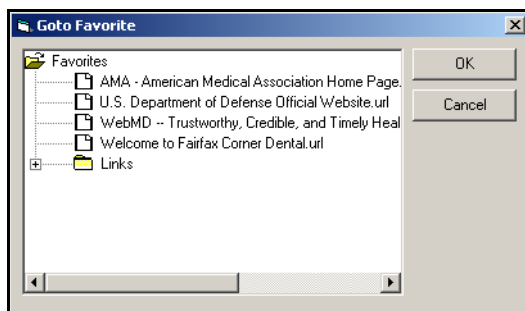


Figure 45-4: Goto Favorite Window

2. Select the desired URL and click **OK**. The site displays in the Workspace.

45.4 Adding to the Favorites List

Follow the steps below to add to the favorites list:

1. Navigate to the website you would like to add to your favorites list.
2. Click **Add** on the Action bar. The Add Favorites window opens.

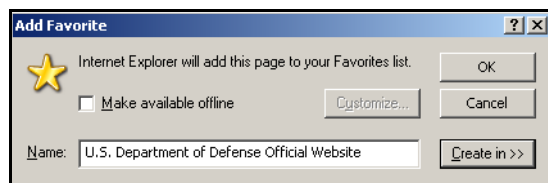


Figure 45-5: Add Favorite Window

Note: Notice that a default website name is displayed in the Name field. You can use this website name, or enter a new name in the Name field. It does not have to be the exact name for the website, but should be something that reminds you of the site.

3. Click **OK**. The website is added to your favorites list.

45.5 Organizing the Favorites List

Once Internet sites are added to your favorites list, you can organize, rename or delete them.

1. Click **Organize** on the Action bar. The Organize Favorites window opens.

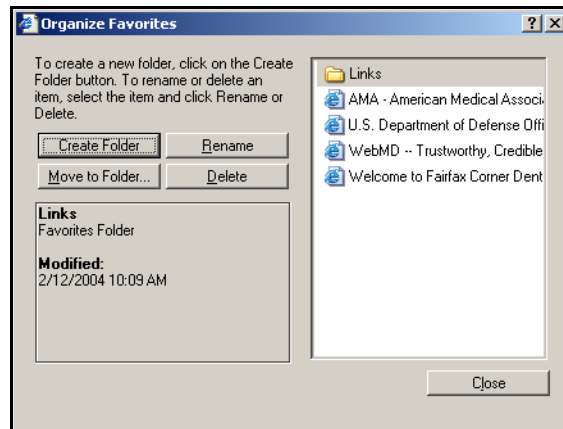


Figure 45–6: Organize Favorites Window

2. Click **Close** after you are finished organizing your favorites list.

45.5.1 Creating a New Folder

Follow the steps below to create a new folder:

1. Click **Create Folder** on the Organize Favorites window. A new folder is created at the end of your favorites list.
2. Enter the name of your new folder and press **Enter** on your keyboard.

45.5.2 Moving a Favorite into a Folder

Follow the steps below to move a favorite into a folder:

1. Select a favorite from the Organize Favorites window and click **Move to Folder**. The Browse for Folder window opens.



Figure 45–7: Browse for Folder Window

2. Select a folder and click **OK**. The favorite is now moved into the selected folder.

45.5.3 Renaming Favorites

Follow the steps below to rename a favorite:

1. Select a favorite from the Organize Favorites window and click **Rename**.
2. Enter the new name of the favorite and press **Enter** on your keyboard. Your favorite is now renamed.

45.5.4 Deleting Favorites

Follow the steps below to delete a favorite:

1. Select a favorite from the Organize Favorites window and click **Delete**. The Confirm File Delete window appears.
2. Click **Yes**. The favorite is now deleted from your favorites list.

45.6 Importing HTML Bookmarks

Follow the steps below to import HTML bookmarks:

1. Click **Import** on the Action bar. The Import Bookmarks HTML into Favorites window opens.
2. Navigate to where the HTML bookmark is stored.
3. Select the HTML bookmark and click **Open**. The Browse for folder window opens.
4. Double-click the favorites folder where you want to convert the bookmarks into favorites and click **OK**. The Import Favorites warning window displays.
5. Click **Yes**. The Import Favorites warning window displays notifying you that favorites were imported successfully.
6. Click **OK**. The bookmarks are now accessible through your favorites list.

45.7 Exporting HTML Bookmarks

Follow the steps below to export HTML bookmarks:

1. Click **Export** on the Action bar. The Browse for folder window opens.
2. Select the folder that contains the favorites you want to export into an HTML bookmark and click **OK**.
3. Navigate to where you want the HTML bookmark to be created.
4. Enter the name of your HTML bookmark in the File Name field and click **Save**. The WebBrowser warning window appears, notifying you that your HTML bookmark was created successfully.
5. Click **OK**.

45.8 Printing Web Pages

Follow the steps below to print a web page:

1. Click **Print WebPage** on the Action bar. The Print window opens.
2. Select your print options and click **Print**.

46.0 WELLNESS

46.1 Wellness Overview

The Wellness module generates preventive health reminders for a patient. These reminders are tied to the United States Preventive Services Task Force guidelines for the general population. Additionally, text-based reminders can be created to notify a provider of special information on a particular patient. Active wellness reminders are placed on the Patient's Problem List area in the Health Maintenance section. Reminders tied to a measurable clinic event, such as a lab test, are automatically addressed as the event is completed. Service that is performed at an outside facility can be manually addressed.

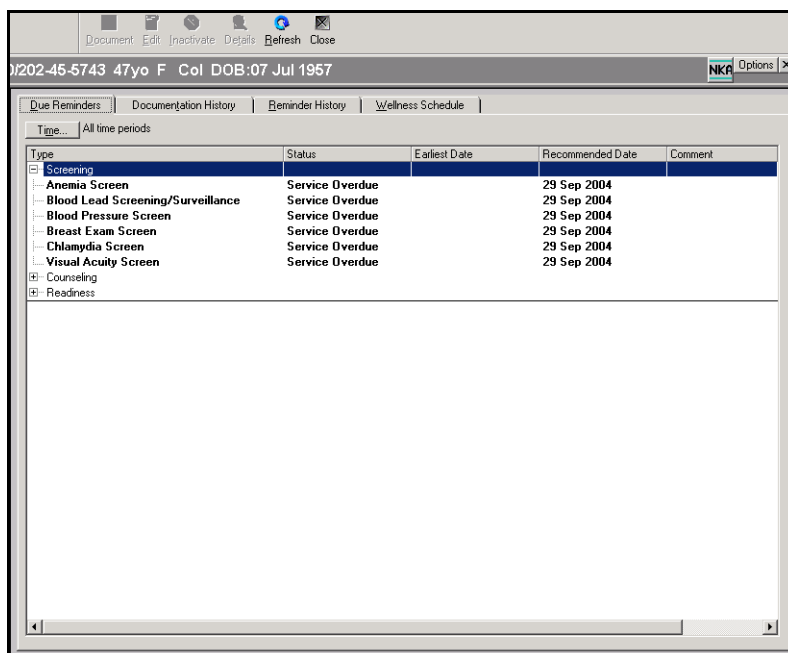


Figure 46-1: Military Clinical Desktop—Wellness Module

46.2 Setting the Filter for the Wellness Module

Click **Options** on the Wellness module or **Filter** on the Documentation History tab to open the Properties window in which display information can be customized.

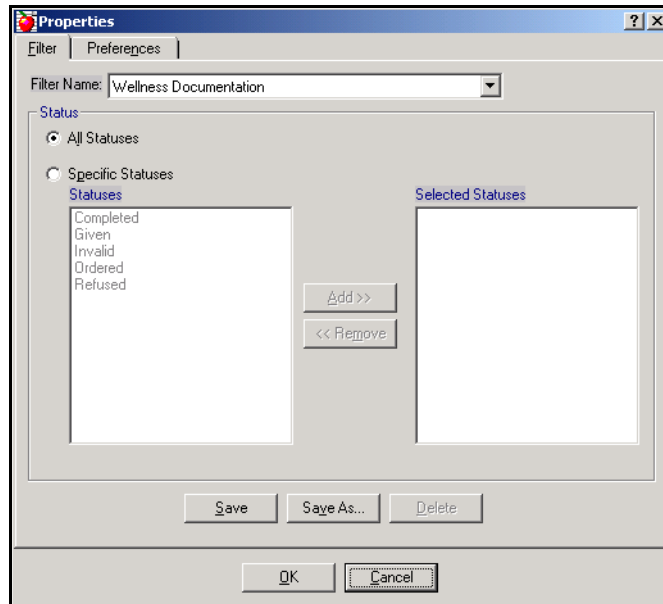


Figure 46–2: Wellness Properties Window—Filter Tab

The Filter tab provides the ability to select a previously saved filter from the drop-down list, or to create a new filter.

Follow the steps below to set the filter for the Wellness module:

1. On the Filter tab, select a **Filter Name** from the drop-down list.
2. Do one of the following:
 - If you want all of the listed statuses to display, select **All Statuses**.
 - If you want to display specific statuses:
 - Select **Specific Statuses**.
 - Select a status from the list.
 - Click **Add** to move the status to the Selected Statuses column.
3. Do one of the following:
 - If this is a new filter selection:
 - Click **Save As**.
 - Enter a new name for the filter.
 - Click **Save**.
 - If this is a change to a pre-existing filter, click **Save**.

46.3 Setting Preferences for the Wellness Module

The Preferences tab allows the time period selection to be used when displaying documented wellness items on the Documentation History tab. Once a time period is selected, it becomes the default setting.

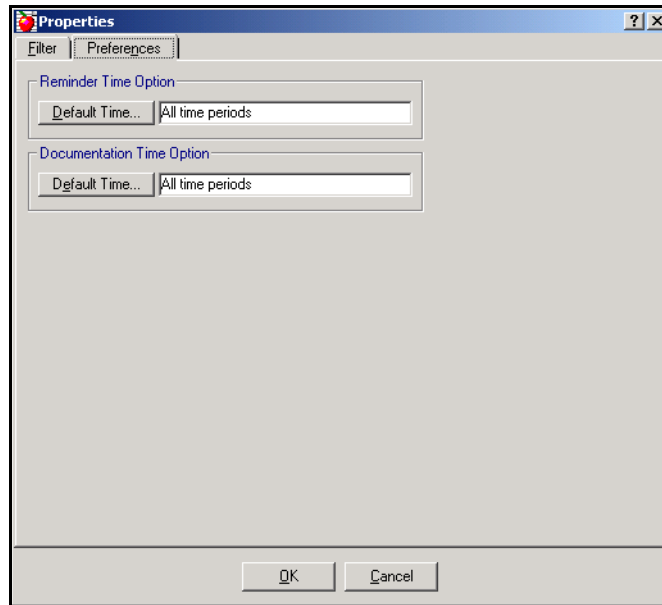


Figure 46–3: Wellness Properties Window—Preferences Tab

Follow the steps below to set preferences for the Wellness module:

1. On the Properties window, select the **Preferences** tab.
2. In the Reminder Time option, click **Default Time** to select a time option for reminders.

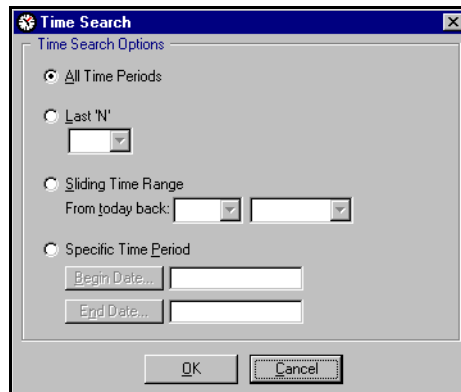


Figure 46–4: Time Search Window

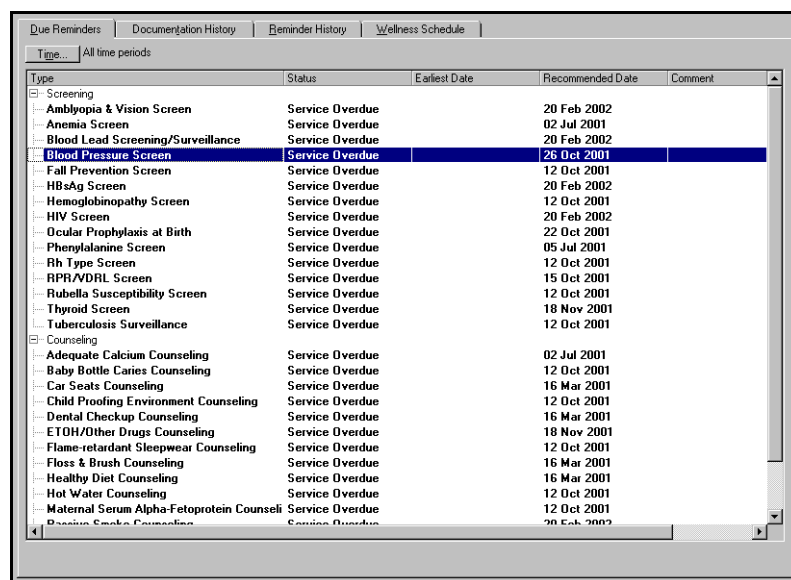
3. In the Time Search window, select time search options for reminders.
4. Click **OK**.

5. In the Documentation Time option, click **Default Time** to select a time option for documentation.
6. In the Time Search window, select time search options for documentation.
7. Click **OK**.
8. Click **OK** to set the time criteria. The data on the Documentation History window is refreshed according to the search criteria.

46.4 Due Reminders Tab

The Due Reminders tab allows you to display active reminders and documentation history (for documented reminders, either manually or automatically) for the current patient. The Due Reminders tab indicates services due in the future or due as of the current date. The tab allows you to alter the schedule of a reminder, as well as display reminders for either all patients or only the currently selected patient. The system displays the Due Reminders list grouped by wellness reminder type and then alphabetically.

Due Reminders are listed with the type of procedure, the status, the earliest date the procedure should be implemented and any comments.



Type	Status	Earliest Date	Recommended Date	Comment
Screening				
Amblyopia & Vision Screen	Service Overdue		20 Feb 2002	
Anemia Screen	Service Overdue		02 Jul 2001	
Blood Lead Screening/Surveillance	Service Overdue		20 Feb 2002	
Blood Pressure Screen	Service Overdue		26 Oct 2001	
Fall Prevention Screen	Service Overdue		12 Oct 2001	
HBsAg Screen	Service Overdue		20 Feb 2002	
Hemoglobinopathy Screen	Service Overdue		12 Oct 2001	
HIV Screen	Service Overdue		20 Feb 2002	
Ocular Prophylaxis at Birth	Service Overdue		22 Oct 2001	
Phenylalanine Screen	Service Overdue		05 Jul 2001	
Rh Type Screen	Service Overdue		12 Oct 2001	
RPR/VDRL Screen	Service Overdue		15 Oct 2001	
Rubella Susceptibility Screen	Service Overdue		12 Oct 2001	
Thyroid Screen	Service Overdue		18 Nov 2001	
Tuberculosis Surveillance	Service Overdue		12 Oct 2001	
Counseling				
Adequate Calcium Counseling	Service Overdue		02 Jul 2001	
Baby Bottle Caries Counseling	Service Overdue		12 Oct 2001	
Car Seats Counseling	Service Overdue		16 Mar 2001	
Child Proofing Environment Counseling	Service Overdue		12 Oct 2001	
Dental Checkup Counseling	Service Overdue		16 Mar 2001	
ETOH/Other Drugs Counseling	Service Overdue		18 Nov 2001	
Flame-retardant Sleepwear Counseling	Service Overdue		12 Oct 2001	
Floss & Brush Counseling	Service Overdue		16 Mar 2001	
Healthy Diet Counseling	Service Overdue		16 Mar 2001	
Hot Water Counseling	Service Overdue		12 Oct 2001	
Maternal Serum Alpha-Fetoprotein Counseli	Service Overdue		12 Oct 2001	
Passive Smoke Counseling	Service Overdue		20 Feb 2002	

Figure 46-5: Wellness Module—Due Reminders Tab

Note: All reminders appear in the Reminder Mapping window and in the A/P Reminders tab.

Note: Reminders are generated through the Wellness module for each individual patient.

46.4.1 Documenting a Due Reminder in the Due Reminders Tab

Follow the steps below to document a due reminder in the Due Reminders tab:

1. Click **Document** on the Action bar. The Document window opens.

Figure 46-6: Document Window

2. Complete the following fields to document the reminder:
 - **Status:** Refers to the status of the reminder:
 - **Completed:** The action has been taken.
 - **Ordered:** The action has been ordered.
 - **Refused:** The action has been refused by the patient.
 - **Clinician:** Enter the name of the person administering the action. The default is whoever is currently logged in. Click **Clinician** to search for a different clinician.
 - **Type:** Select the action to be taken from the drop-down list. The default is the task for which the reminder is being documented.
 - **Coded:** Select a more detailed status of service from the drop-down list. For example, *Preventive Service Completed Report Reviewed*.
 - **Free-text:** Enter any additional comments in the field.
 - **Date:** Select the date the action occurred.
 - **Information Source:** Select the relationship to the patient reporting the action from the drop-down list.
 - **Admin. Location:** Enter the location where the action occurred.
3. Click **Save**.

46.4.2 Editing a Due Reminder in the Due Reminders Tab

Follow the steps below to edit a due reminder in the Due Reminders tab:

1. Select an item from the list on the Due Reminders tab.
2. Click **Edit** on the Action bar. The Edit window opens. Coded and free-text Comments are the only two fields that can be changed.

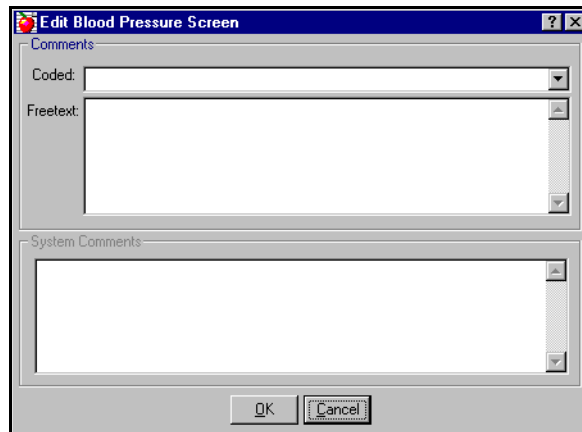


Figure 46-7: Edit Due Reminders Window

3. Select a code from the drop-down list.
4. Enter any free-text to further explain the code or in place of the code.
5. Click **OK**.

46.4.3 Inactivating a Due Reminder in the Due Reminders Tab

Inactivating a reminder prevents it from being generated.

Follow the steps below to inactivate a reminder in the Due Reminders tab:

1. Select a reminder from the Due Reminder list.
2. Click **Inactivate** on the Action bar.
3. At the Confirm Inactivation prompt, click **Yes**. The Inactivation window opens.

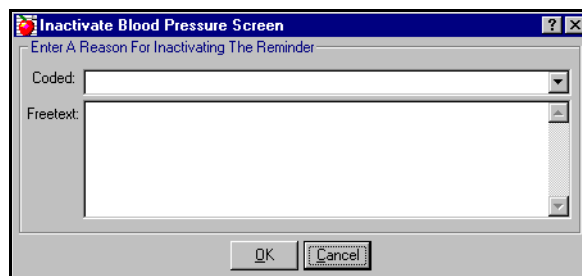


Figure 46-8: Inactivate Due Reminders Window

Tip:

To activate an item that has been inactivated, select the Wellness Schedule tab to activate the selected reminder.

4. Select a code from the coded drop-down list.

5. Enter any free-text to further explain the code or to take the place of a code.
6. Click **OK**.

46.4.4 Viewing Due Reminder Details in the Due Reminders Tab

Follow the steps below to view due reminder details in the Due Reminder tab:

1. Select the reminder on the Due Reminders tab.
2. Click **Details** on the Action bar. The Detail Information window opens.

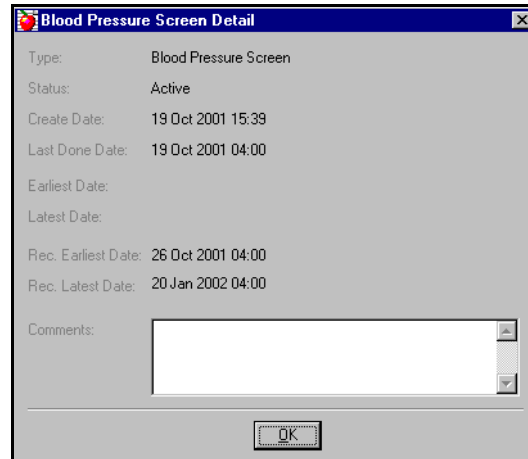


Figure 46-9: Due Reminders Detail Window

3. After viewing the due reminder information, click **OK** to close the window.

46.4.5 Adding a Wellness Schedule in the Due Reminders Tab

Follow the steps below to add a wellness schedule in the Due Reminders tab:

1. Click **Add** on the Action bar. The Add Wellness Schedule window opens.

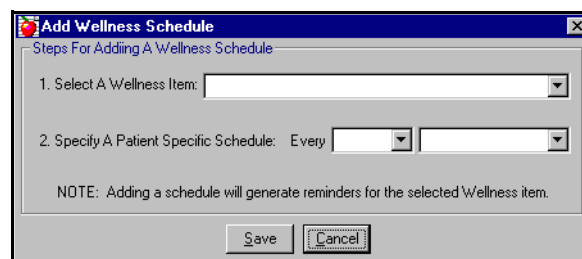


Figure 46-10: Add Wellness Schedule Window

2. Select a **Wellness Item** from the drop-down list.
3. Select a Patient Specific Schedule from the drop-down lists to document the frequency of the wellness item.
4. Click **Save** to save the new schedule.

46.5 Documentation History Tab

The Documentation History tab allows you to define all Wellness-related events, including Immunizations or satisfaction of Wellness Reminders. The Documentation History tab allows you to document the appropriate service for the selected reminder. The tab also allows you to select either a coded or free-text comment to associate with a Wellness Reminder.

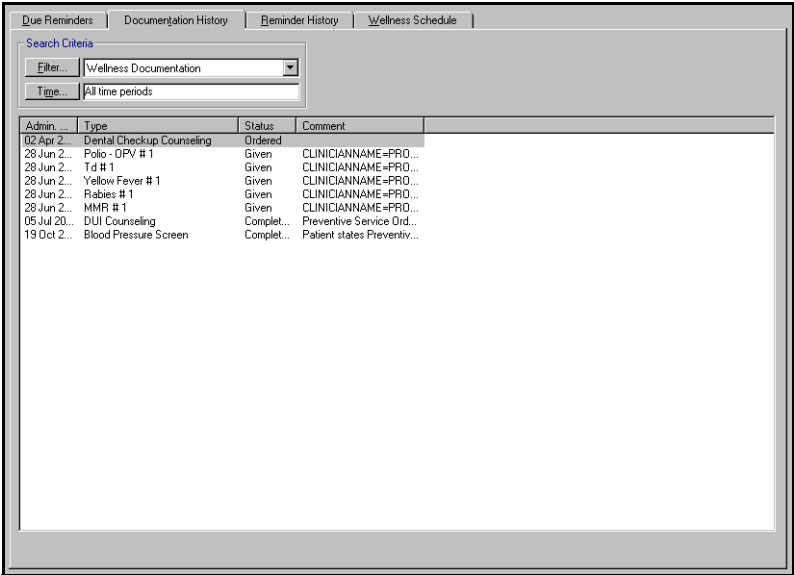


Figure 46–11: Wellness Module— Documentation History Tab

46.5.1 Adding a Reminder History in the Documentation History Tab

Follow the steps below to add a reminder history in the Documentation History tab:

1. Click **Add History** on the Action bar. The Select History Type window opens.

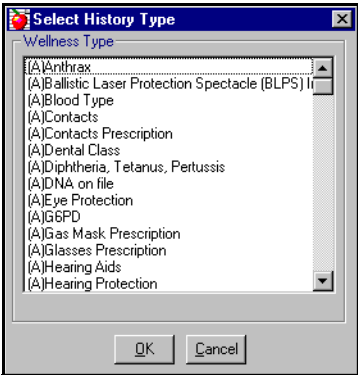


Figure 46–12: Select History Type Window

2. Select the desired procedure.

3. Click **OK**. The new History window opens with the clinician's name and type pre-filled.

Note: The **Date**, **Information Source**, and **Status** are required fields.

Figure 46-13: History Window

4. Complete the required fields.
 - **Status:** The status can be changed to Completed, Ordered, or Refused.
 - **Date:** Select the date the action occurred.
 - **Information Source:** Enter the relationship to the patient reporting the action.
5. Update information in the remaining fields, if necessary.
 - **Clinician:** Enter the name of the person administering the action. The default is whoever is currently logged in.
 - **Type:** Select the action to be taken from the drop-down list. The default is the task for which the reminder is being documented.
 - **Coded:** Select a more detailed status of service by accessing the drop-down list.
 - **Free-text:** Enter any additional comments.
 - **Admin. Location:** Enter the location where the action occurred.
6. Click **Save** to add this reminder history information to the documentation history list.

46.5.2 Deleting Documentation History in the Documentation History Tab

Follow the steps below to delete documentation history in the Documentation History tab:

1. Select the item to be deleted.
2. Click **Delete** on the Action bar.
3. On the Confirm Deletion prompt, click **Yes** to delete.

46.5.3 Editing a Reminder History in the Documentation History Tab

Follow the steps below to edit a reminder history in the Documentation History tab:

1. Select the reminder to be modified.
2. Click **Edit** on the Action bar. The Documentation History Edit window opens.

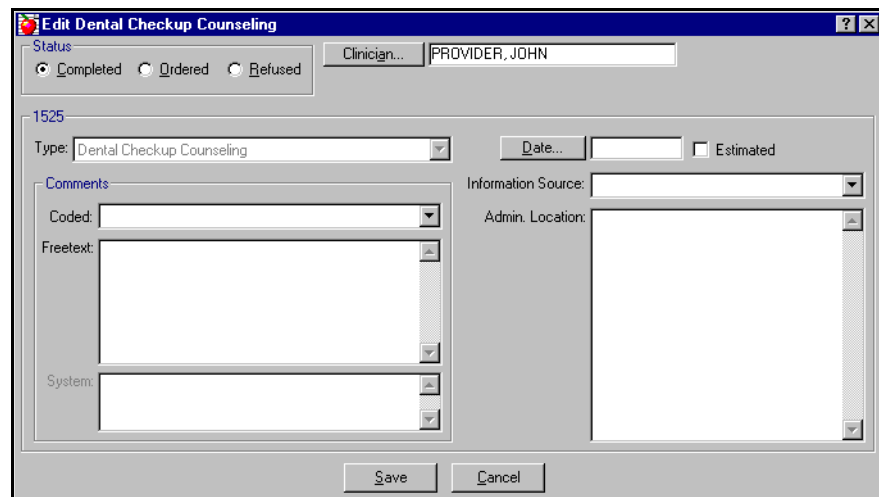


Figure 46-14: Documentation History Edit Window

3. Modify the desired data.
4. Click **Save**.

46.5.4 Reminder History Tab

The Reminder History tab displays a history of reminders.

Type	Status	Earliest...	Recommended...	Comment
Down Syndrome Marker Testing	Canceled	02 Jul 2001		
Verify eye mask insert exam <1 yr ago	Canceled	26 Jun 2001		
Verify eye glasses exam <1 yr ago	Canceled	16 Mar 2001		
Total Cholesterol Screen	Canceled	16 Mar 2001		
Tobacco Cessation Counseling	Canceled	16 Mar 2001		
STD Prevention	Canceled	16 Mar 2001		
Helmets Counseling	Canceled	16 Mar 2001		
Height & Weight Screen	Canceled	16 Mar 2001		
Prostate-Specific Antigen (PSA) ...	Canceled	16 Mar 2001		
Blood Pressure Screen	Documen...	16 Mar 2001		
Strabismus Screen	Canceled	16 Mar 2001		
Firearms Counseling	Canceled	16 Mar 2001		
Smoke Detector Counseling	Canceled	16 Mar 2001		Expired
Safety Belt Counseling	Canceled	16 Mar 2001		
Problem Drinking Assessment	Canceled	16 Mar 2001		
DUI Counseling	Documen...	16 Mar 2001		
Multivitamin With Folate	Canceled	16 Mar 2001		
Urine Cx	Canceled	26 Jun 2001		
Verify HIV test <1yr ago	Canceled	26 Jun 2001		
Verify Physical exam	Canceled	05 Jul 2001		
Hearing Protection	Canceled	05 Jul 2001		

Figure 46-15: Wellness Module—Reminder History Tab

46.5.5 Setting the Time Filter in the Reminder History Tab

Follow the steps below to set the time filter in the Reminder History tab:

1. Click **Time**. The Time Search window opens.

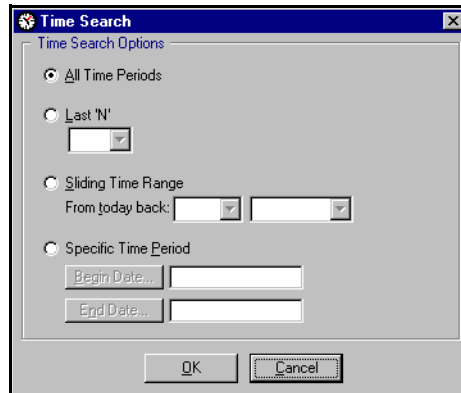


Figure 46-16: Time Search Window

2. Select **Time Search Options** for reminders.
3. Click **OK**. The data on the Reminder History List screen is refreshed according to the search criteria.

46.5.6 Editing a Reminder History in the Reminder History Tab

Follow the steps below to edit a reminder history in the Reminder History tab:

1. Select the Reminder History to be modified.
2. Click **Edit** on the Action bar. The Edit Reminder window opens.

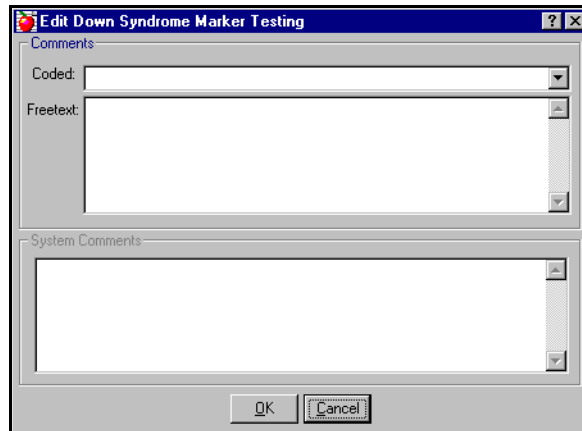


Figure 46-17: Due Reminder Edit Window

3. Select a code from the coded drop-down list.
4. Enter any necessary free-text to provide further explanation or to take the place of a code.
5. Click **OK**.

46.5.7 Activating/Inactivating a Reminder in the Reminder History Tab

The Activate/Inactivate button toggles between activate and inactivate depending on the state of the selected reminder. If the reminder is already active, the **Inactivate** button is seen. If the reminder is inactive, the **Activate** button is seen.

Follow the steps below to activate/inactivate a reminder in the Reminder History tab:

1. Select the inactive reminder.
2. Click **Activate** on the Action bar.
3. On the Confirm Reminder Activation window, click **Yes**.

Follow the steps below to inactivate a reminder:

1. Select the active reminder.
2. Click **Inactivate** on the Action bar. The Inactivation window opens.

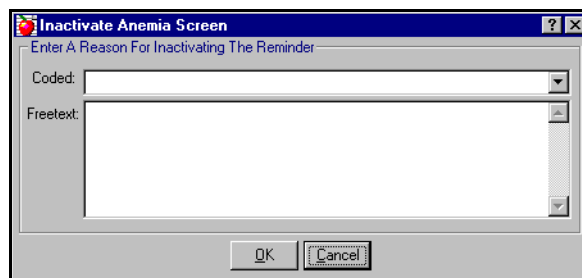


Figure 46-18: Inactivate Reminder Window

3. Enter a reason for the inactivation as a coded or free-text comment.

4. Click **OK**.
5. On the Confirm Inactivation window, click **Yes** to inactivate the reminder.

46.5.8 Viewing Reminder History Details in the Reminder History Tab

Follow the steps below to view reminder history details in the Reminder History tab:

1. Select the reminder.
2. Click **Details** on the Action bar. The Detail Information window opens.

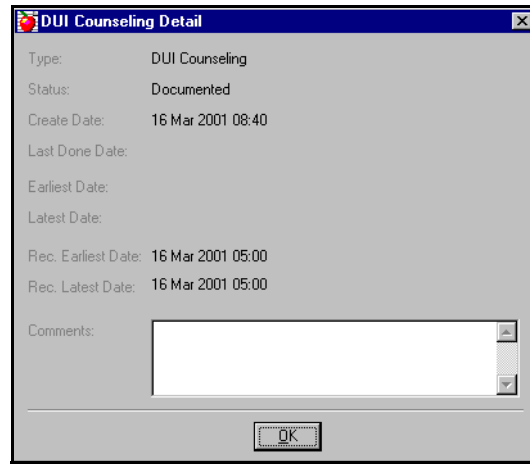


Figure 46–19: Due Reminder Detail Window

3. View the detailed reminder information in the window.
4. Click **OK**.

46.6 Wellness Schedule Tab

The Wellness Schedule tab displays the type of action, the administration schedule, the status of the reminder and a comment.

Type	Schedule	Reminder	Comments
Screening			
Amblyopia & Vision Screen	Every 5 days	Generate	
Anemia Screen	Every 4 months	Generate	
Blood Lead Screening/Surveillance	Every 2 days	Generate	
Blood Pressure Screen	Every 7 days	Generate	
Down Syndrome Marker Testing	Every 3 months	Generate	
Fall Prevention Screen	Every 2 months	Generate	
HBsAg Screen	Every 11 days	Generate	
Height & Weight Screen	Every 3 months	Do Not Generate	
Hemoglobinopathy Screen	Unavailable	Generate	
HIV Screen	Every 12 days	Generate	
Ocular Prophylaxis at Birth	Every 2 months	Generate	
Phenylalanine Screen	Every 10 days	Do Not Generate	
Problem Drinking Assessment	Every 1 years	Do Not Generate	
Prostate-Specific Antigen (PSA) Screening	Every 2 months	Generate	
Rh Type Screen	Every 1 months	Generate	
RPR/VDRL Screen	Every 5 days	Generate	
Rubella Susceptibility Screen	Every 1 months	Generate	
Strabismus Screen	Every 10 days	Do Not Generate	
Thyroid Screen	Every 3 days	Generate	
Total Cholesterol Screen	Every 1 years	Do Not Generate	
Tuberculosis Surveillance	Every 1 months	Generate	
Urine Cx	Unavailable	Do Not Generate	
Visual Acuity Screen	Every 1 months	Generate	
Counseling			
Adequate Calcium Counseling	Every 3 days	Do Not Generate	
Baby Bottle Caries Counseling	Every 1 days	Generate	
Car Seats Counseling	Every 3 months	Generate	
Child Proofing Environment Counseling	Every 1 years	Generate	
Dental Checkup Counseling	Every 1 months	Generate	
DUI Counseling	Every 1 months	Generate	

Figure 46–20: Wellness Module—Wellness Schedule Tab

46.6.1 Adding a Wellness Schedule Reminder in the Wellness Schedule Tab

Follow the steps below to add a wellness schedule reminder in the Wellness Schedule tab:

1. Click **Add** on the Action bar. The Add Wellness Schedule window opens.

Figure 46–21: Add Wellness Schedule Window

2. Select a wellness item from the drop-down list.
3. Specify a patient schedule using the drop-down list to document the frequency of the wellness item.
4. Click **Save**.

46.6.2 Editing a Wellness Schedule Reminder in the Wellness Schedule Tab

Follow the steps below to edit a wellness schedule reminder in the Wellness Schedule tab:

1. Select the reminder to be modified.

- Click **Edit** on the Action bar. The Reminder Schedule window opens.

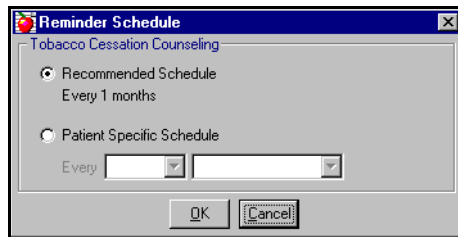


Figure 46-22: Reminder Schedule Window

- Do one of the following:
 - If you want the wellness schedule reminder to occur once a year, select the Recommended Schedule radio button.

Note: Recommended schedule varies based on the type of test—does not automatically set reminders to one year in all cases.

- If you want to establish a patient-specific schedule:
 - Select **Patient Specific**.
 - Select a time from the drop-down list.
- Click **OK** to set the reminder schedule.

46.6.3 Activating/Inactivating a Wellness Reminder in the Wellness Schedule Tab

The Activate/Inactivate button toggles between activate and inactivate depending on the state of the selected reminder. If the reminder is already active, the **Inactivate** button is seen. If the reminder is inactive, the **Activate** button is seen.

Follow the steps below to activate a wellness reminder in the Wellness Schedule tab:

- Select the inactive reminder.
- Click **Activate** on the Action bar. The Confirm Reminder Activation window opens.

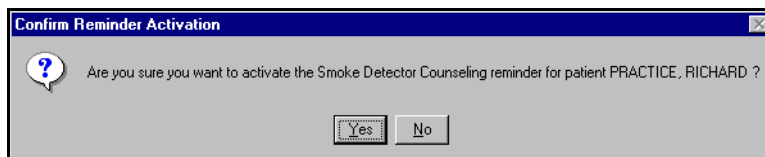


Figure 46-23: Confirm Reminder Activation Window

- Click **Yes** to activate the reminder.

Follow the steps below to inactivate a reminder in the Wellness Schedule tab:

- Select a reminder.

2. Click **Inactivate** on the Action bar.
3. On the Confirm Inactivation window, click **Yes**. The Inactivation window opens.

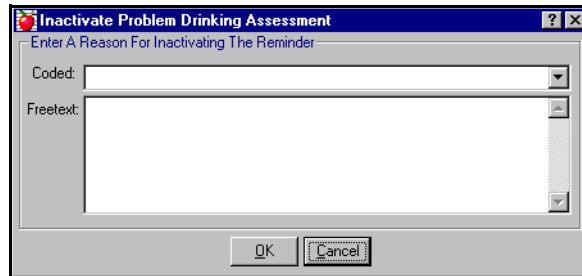


Figure 46–24: Inactivation Window

4. Select a code from the drop-down list or type free-text in place of the code.
5. Click **OK**.